STATE OF CALIFORNIA
DEPARTMENT OF CONSUMER AFFAIRS
STATE AND CONSUMER SERVICES AGENCY • ARNOLD SCHWARZENEGGER, GOVERNOR
BOARD OF REGISTERED NURSING
P.O. Box 944210, Sacramento, CA, 94244-2100
P (916) 322-3350 | www.rn.ca.gov
Louise Bailey, M.Ed., RN, Executive Officer

NURSING PRACTICE COMMITTEE MEETING

AGENDA

Hilton San Diego Mission Valley
901 Camino del Rio South
San Diego, CA 92108
Phone: 619-543-9000

January 5, 2011

Wednesday, January 5, 2011 – 1:30 pm – 2:30 pm

10.0 Review and Approve Minutes
- Ø May 18, 2010
- Ø July 13, 2010
- Ø September 22, 2010
- Ø November 16, 2010

10.1 Report on the Goals and Objectives 2010

10.2 Registered Nurse Advisories
- Abandonment of Patients
- An Explanation of the Scope of RN Practice Including Standardized Procedures
- Complementary and Alternative Therapies in Registered Nursing Practice
- Nursing Student Workers
- RN Tele-Nursing and Telephone Triage
- Reproductive Privacy Act
- Standardized Procedures Guidelines
- Standards of Competent Performance
- The RN as the First Assistant to the Surgeon

10.3 Public Comment for Items Not on the Agenda

NOTICE:
All times are approximate and subject to change. Items may be taken out of order to maintain a quorum, accommodate a speaker, or for convenience. The meeting may be canceled without notice. For verification of the meeting, call (916) 574-7600 or access the Board's Web Site at http://www.rn.ca.gov. Action may be taken on any item listed on this agenda, including information only items.

Public comments will be taken on agenda items at the time the item is heard. Total time allocated for public comment may be limited.

The meeting is accessible to the physically disabled. A person who needs a disability-related accommodation or modification in order to participate in the meeting may make a request by contacting the Administration Unit at (916) 574-7600 or email webmasterbrn@dca.ca.gov or send a written request to the Board of Registered Nursing Office at 1625 North Market #N-217, Sacramento, CA 95834. (Hearing impaired: California Relay Service: TDD phone # (916) 322-1700). Providing your request at least five (5) business days before the meeting will help to ensure the availability of the requested accommodation.

Board members who are not members of this committee may attend meetings as observers only, and may not participate or vote. Action may be taken on any item listed on this agenda, including information only items. Items may be taken out of order for convenience, to accommodate speakers, or maintain a quorum.

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Louise Bailey, M.Ed, RN, Interim Executive Officer

DRAFT

NURSING PRACTICE COMMITTEE MEETING
MEETING MINUTES

DATE: May 18, 2010

TIME: 3:00 PM – 4:00 PM

LOCATION: Hilton Orange County
3050 Bristol Street
Costa Mesa, CA 92626
Phone: (916) 574-7600
Fax: (916) 574-7700

COMMMITTEE MEMBERS PRESENT:

Kathrine Ware, MSN, RN, ANP-C Chair
Nancy Beecham, BS, RNC
Catherine Todero, PhD, RN

OTHERS PRESENT:

Janette Wackerly, MBA, RN NEC Liaison
Louise Bailey, Interim Executive Officer
Geri Nibbs, NEC
Miyo Minato, NEC
Kay Weinkam, NEC
Katie Daugherty, NEC
Heidi Goodman, Asst EO
Louisa Gomez, Program Manager
Leslie Moody, NEC
Shelly Ward, NEC
Judith Martin-Holland, Associate Dean UCSF
Nancy Spavan
Kelly Green, CNA
Jill Omstead, NP, CANP
Trisha Hunter, RN, ANA/C
Julie Campbell-Warnock, Research Specialist

Kathrine Ware, Chair opened the meeting shortly after 4:00 pm. and had the committee members introduce themselves.

11.0 Review and Approve:

Ø May 18, 2010

MSC: Todero/Beecham that the Committee approve minutes from February 24, 2010.

11.1 APRN Consensus: Issues related to the Regulatory Model by Colleen Keenan PhD, CANP Board of Director, Chair Practice Committee

Colleen Keenan PhD, RN Chair Practice Committee, California Association of Nurse Practitioners gave a presentation to the Committee on the APRN (Advanced Practice Registered Nurse) Consensus.

Introduced in 2008, the APRN Consensus Regulatory Model is a nationally developed process designed to ensure high quality patient care and safety delivered by advanced practice nurses. Four dimensions of regulation model (LACE) include education and program accreditation, individual APRN national certification and licensure within an APRN role and population. The presentation objectives included:

- Review the components of the APRN Consensus Regulatory Model from a *Nurse Practitioner* Perspective
- Present the national timeline related to planned implementation of the LACE framework
- Provide opportunities for discussion concerning application of the regulatory model in California.

For information: Nursing Practice Committee January 15, 2009 and Draft Consensus Model for APRN Regulation: Licensure, Accreditation, Certification & Education June 18, 2008.

11.2 Barriers to Nursing Student Clinical Practice:

Kathrine Ware, Chairperson, requested persons in the audience to report on their experience with any barriers to nursing student clinical practice.

Comments made during Nursing Practice Committee Meeting on May 18, 2010, are as follows:

Judy Martin-Holland, Associate Dean, UCSF
Barriers to Nursing Student Clinical Practice:

- Electronic Medical Record (EMR), Pyxis (Medications), and OmiCell (Supplies) have created a natural impediment to nursing student experiences obtaining and passing medications. After much discussion and negotiating, limited access to charting and medication has been obtain in many of the clinical settings for students, but the process of obtaining access and using the limited access provided is highly laborious.

- Pediatric and psychiatric settings – many require the student have a facility RN at the student's side during medication administration. The Clinical Faculty or Clinical Instructor in some instances is not enough, facilities require a bedside nurse. This can

represent a perception of time drain for RNs who then in some cases refuse to work with patients for which students have been assigned.

- Pharmacists are putting policies in place to restrict student access to medications and administration of medication. A few pharmacist colleagues have reported receiving information from the "pharmacy board" (be it the CA Pharmacy Bd or a professional association – unclear), but they are saying the Prof Code 2729 document previously distributed by Ruth Ann Terry, is not strong enough evidence to substantiate student access to medication.

- Hospitals and medical centers are frequently canceling student rotations/clinical experiences, sometimes with less than a day notice, when notified of a Joint Commission or CMS visit.

- Students must complete multiple modules and other pre-clinical rotation facility-based learning activities before setting foot in each clinical facility. The majority of these modules are repetitive of information/activities required by the School and other area facilities. Completion of these modules/activities take an average of 8-10 hours per setting, per student. Students moving from a pediatric rotation to a psych rotation, to a med-surg rotation in one quarter, may spend up to 30 hours completing repetitious modules (HIPPA, Handwashing, Falls, Verbal Orders, etc.). This information is above and beyond facility specific responses such as what to do in case of fire (where to call, how to respond), Code designations (blue, patient out of control, etc.).

- The Joint Commission has a document guiding facilities who have volunteer and contract personnel in their facilities. Some facilities consider nursing students in this category of "visitor" in the facility. The document greatly limits sharing patient information and student involvement with patient care. Facilities who stringently use this document limit students to observatory roles limiting student-patient interaction.

- Additionally, on the Advanced Practice side of our education programs, pharmacists limit licensed Registered Nurses who are in a graduate advanced practice program to have access to medications or to administer medications.

- Licensed RNs in a graduate program are still not allowed access to EMR.

- Liability concerns are used to control student-patient interactions for students in the advanced practice program. We're told the students "must be supervised at all times".

- Advanced practice nurses report patient volume expectations cannot be maintained while a student is being precepted, so they restrict access to our students.

- Liability language required by the UC's limits midwifery student ability to experience home and other alternative birth locations.

Dr Nancy Cowen MS.EdD Director at Chabot College was unable to attend the meeting and requested to present the findings of the northern ADN Directors at the July 13, 2010 meeting.

Dr. Nancy Cowen MS, EdD, RN Director at Chabot Colleges and president of the Northern California Associate Degree Nursing Director Group will provide survey information on items of concern. Vicky Maryatt, RN MSN Director American River College and Roz Hartman MSN, RN Director at College of Marin produced the survey with results which will be brought to the committee meeting.

Northern Associate Degree Nursing Programs are experiencing difficulty with aspects of nursing student clinical affiliations in acute care and in some instances inability of nursing students to perform glucometer testing, access to medication including narcotics, access to the electronic medical record, and limiting Bar Coding Medication Administration. Faculties are experiencing changes in acute care where nursing student learning opportunities have been declining in the hospitals.

11.3 Public Comment for Items Not on the Agenda

11.4 Open Forum No public comment was made.

Submitted by:

_____
Janette E. Wackerly, MBA

Approved by:

_____
Kathrine Ware, MSN, RN, ANP-C Chair

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Louise R. Bailey, M.Ed., RN Interim Executive Officer

Draft

NURSING PRACTICE COMMITTEE MEETING
MEETING MINUTES

DATE: July 13, 2010

TIME: 1:00 PM

LOCATION: DCA Headquarters
1625 North Market Blvd
Hearing Room S-102
Sacramento, CA 95834

COMMITTEE MEMBERS PRESENT:
Kathrine Ware MSN, RN, ANP-C Chair
Erin Niemela

OTHERS PRESENT:
Janette Wackerly, MBA, RN, NEC Liaison
Louise Bailey, M.Ed., RN, Interim Executive Officer
Heidi Goodman, Assistant Executive Officer, BRN
Badrieh Caraway, RN, NEC
Geri Nibbs, RN, NEC
Katie Daugherty, RN, NEC
Kay Weinkam, RN, NEC
Kelly McHan, RN, NEC
Miyo Minato, RN, NEC
Shelly Ward RN, NEC
Leslie Moody RN, NEC
Pat McFarland EO, ACNL
Bobbie Pierce, Licensing
Crystal Silva, Licensing
Nancy Spradling, CSNO
Candace Campbell, ANA/C
Kelly Green, CNA
Myrna Allen, ANA/C
Vickie Maryatt, RN, MSN, Director American River College
Nancy Cowne, MS, EdD, Emeritus Director
April Reed, Samuel Merritt University
Sue Starck, Carrington College
Grace Corse, SEIU Nurse Alliance

Kathrine Ware, Chair opened the meeting shortly after 1:00 pm and the committee members introduced themselves.

9.0 Review and Approve Minutes:

- Ø July 13, 2010
- Ø May 18, 2010

MSC: Minutes were held over to the next committee meeting for approval.

9.1 BRN Study of California RNs on Probation 2004-2005

BRN staff is working with Joanne Spetz and other research staff from the University of California, San Francisco Center for the Health Professions to complete a report on a study of California RNs who either began or extended probation in 2004 or 2005, which totals approximately 275 cases. This study is based on one published in March 2009 in the American Journal of Nursing. The National Council of State Boards of Nursing (NCSBN) worked with six boards of nursing to explore and evaluate what factors might affect the outcomes of remediation, including the likelihood of recidivism. A 29-item data extraction template was used to obtain data on the characteristics of the disciplined nurses, their employment settings, board actions, and remediation outcomes. A control group of nurses who had not been disciplined were used to compare data against the disciplined nurses.

BRN staff began collecting data on the California RNs in October 2009 using a modified version of the 29-item data collection instrument. Some additional data elements were collected which are outlined in the attached study overview. The collected data was provided to UCSF in May 2010 and they have begun working on the data entry and analysis. The final report is estimated to be completed in late October or early November 2010.

9.2 Barriers to Nursing Student Clinical Practice

Dr Nancy Cowen MS, EdD, RN Director at Chabot Colleges and President of the Northern California Associate Degree Nursing Director Group provided survey information on items of concern: Cynthia Harrison, RN, MSN, Director Mission College, Vicky Maryatt, RN MSN Director American River College and Roz Hartman MSN, RN Director at College of Marin were involved with producing the survey tool.

In spring 2010 nursing programs were notified of loss of their clinical placements for students in acute care units, OB, Mental Health, Pediatrics, Medical Surgical and Geriatrics. The individual colleges and the number of students affected by clinical placement loss will be discussed as demonstrated in the survey. Clinical placements for fall 2010 have not been confirmed.

Northern Associate Degree Nursing Programs are experiencing difficulty with aspects of nursing student clinical affiliations in acute care and in some instances inability of nursing students to perform glucometer testing, access to medication including routine medications, IV administration and narcotics, access to the electronic medical record, and limiting Bar

Coding Medication Administration. Faculties are experiencing changes in acute care where nursing student learning opportunities have been declining in some hospitals.

9.3 Report CALNOC Conference: The Global Reach of Nursing Quality

Collaborative Alliance for Nursing Outcomes, CALNOC, June 23-24, 2010 Conference "The Global Reach of Nursing Quality" was held at the South San Francisco Conference Center.

Keynote address by Craig Clapper, PE, CMO/OE, founding partner and COO Health Performance Improvement spoke about Making Reliability a Reality: Quality Interest in the Patient Safety Culture.

Mary Foley PhD, RN Assistant Director, Center for Research and Innovation in Patient Care, UCSF School of Nursing, addressed CALNOC Medication Administration Accuracy through the art and logistics of naïve observation, planning data collection, leveraging the observational moment, drilling down on distraction, documentation and patient education, using the CALNOC measure to evaluate practice and EHR innovations.

Nancy Donaldson, DNSc, RN FAAN, co-principle investigator, CALNOC, Director, Center for Nursing and Research and Innovation, UCSF School of Nursing, presented Medication Administration Accuracy, the link between safe practices and medical administration errors.

Medication Administration Accuracy a local project that illuminates the problems and interventions in the nurse sensitive factors in medication administration. Seven hospitals from the San Francisco Bay Area participated in an 18 month-long Integrated Nurse Leadership Program, which was designed to improve reliability of medication administration and used the CALNOC Medication Administration Accuracy Tool.

Pam Wells RN, MSN, Vice President and Chief Nursing Officer, Lucille Packard Children's Hospital, Palo Alto, CA presented exemplar-using the CALNOC Medication Administration Accuracy Measure to explore the impact of electronic health record implementation.

CALNOC – Mission is to advance global patient care safety, outcomes and performance measurement efforts by: Leveraging a dynamic nursing outcomes database and reporting system; providing actionable data to guide decision making performance improvement, and public policy; conducting research to optimize patient care excellence; building leadership expertise in the use of practice-based evidence.

The following people made a comment:
Victoria Marriot, Director of American River College
Nancy Cowan Pinro, Director of Chabot College
Pat McFarland, Association of California Nurse Leaders

9.4 Public Comment for Items Not on the Agenda

No public comment was made.

Submitted by:

_____
Janette E. Wackerly, MBA
Chair

Approved by:

_____
Kathrine Ware, MSN, RN, ANP-C

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Louise R. Bailey, M.Ed., RN Interim Executive Officer

Draft

NURSING PRACTICE COMMITTEE MEETING
MEETING MINUTES

DATE: September 22, 2010

TIME: 1:00 PM

LOCATION: Hilton San Diego Mission Valley
901 Camino del Rio South
San Diego, CA 92108

COMMITTEE MEMBERS PRESENT:
Nancy Beecham, RN-BC acting Chair
Erin Niemela

OTHERS PRESENT: Janette Wackerly, MBA, RN, NEC Liaison, Louise Bailey, M.Ed., RN, Interim Executive Officer, Maria Bedroni, MSN, RN SNEC, Heidi Goodman, Assistant Executive Officer, BRN, Badrieh Caraway, RN, NEC, Geri Nibbs, RN, NEC, Katie Daugherty, RN, NEC, Kay Weinkam, RN, NEC, Kelly McHan, RN, NEC, Miyo Minato, RN, NEC, Shelly Ward RN, NEC, Leslie Moody RN, NEC, Carol Mackay, MN, RN, NEC, Bobbie Pierce, Licensing Manager, Kathy Hodge Enforcement, Julie Campbell-Warnock Research Program Specialist

Nancy Beecham, acting Chair opened the meeting shortly after 1:00 pm and the committee members introduced themselves.

10.0 Review and Approve Minutes:
- Ø September 22, 2010
- Ø July 13, 2010
- Ø May 18, 2010

MSC: Minutes were held over to the next committee meeting for approval.

10.1 BRN survey of California Nurse Practitioners, Certified Nurse-Midwives and Clinical Nurse Specialists

Julie Campbell-Warnock Research Program Specialist gave the following report.

The BRN is working with Joanne Spetz and other research staff from the University of California San Francisco (UCSF), Center for the Health Professions to complete a survey of California Nurse Practitioners, Certified Nurse-Midwives and Clinical Nurse Specialists. The purpose of the survey is to learn information about demographics,

education, employment, practice and standardized procedure use from these advanced practice nurses in California. There has not been much data collected from these advanced practice registered nurses nationally or in other states so there is interest nationally in the data that will be collected.

On June 30, 2010, the BRN had a brainstorming meeting/conference call with UCSF staff to discuss information to collect, ideas for the best way to collect the data and determine potential subject matter experts to further assist in survey development. UCSF then developed two sample surveys, one for Nurse Practitioners and Certified Nurse-Midwives and one for Clinical Nurse Specialists. There are some overlapping questions between the two surveys and some unique questions to target information from each specific advanced practice specialty area. On August 23, 2010, the BRN and UCSF staff had another meeting/conference call with subject matter experts representing the different advanced practice areas to refine the survey instruments. The subject matter experts were:

- Ann Mayo, Professor at Hahn School of Nursing and Health Science in San Diego representing Clinical Nurse Specialists

- Colleen Keenan, Interim Director of Nurse Practitioner Program at UCLA School of Nursing, representing Nurse Practitioners

- BJ Snell, Faculty Director at California State University, Fullerton, representing Certified Nurse-Midwives (she was not able to join the call but it is hoped she can provide feedback via e-mail).

The surveys are now being finalized and field tested, and are expected to be sent to a total sample of 5,000 to 6,000 California registered nurses certified in these advanced practice areas in mid-October. Data from the survey will be analyzed and a report completed by UCSF, discussing the findings, is expected by June 2011.

10.2 Public Comment for Items Not on the Agenda
No Public input.

Submitted by:

_____
Janette E. Wackerly, MBA
Chair

Approved by:

_____
Kathrine Ware, MSN, RN, ANP-C

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Louise R. Bailey, M.Ed., RN Interim Executive Officer

Draft

NURSING PRACTICE COMMITTEE MEETING
MEETING MINUTES

DATE: November 16, 2010

TIME: 1:30 PM

LOCATION: Department of General Services
Elihu Harris State Building
1515 Clay Street
Conference Center, 2nd Floor
Oakland, CA 94612
Phone: 510-622-2564

COMMITTEE MEMBERS PRESENT:
Nancy Beecham, RN-BC acting Chair
Erin Niemela

OTHERS PRESENT: Janette Wackerly, MBA, RN, NEC Liaison, Louise Bailey, M.Ed., RN, Interim Executive Officer, Maria Bedroni, MSN, RN SNEC, Heidi Goodman, Assistant Executive Officer, BRN, Badrieh Caraway, RN, NEC, Geri Nibbs, RN, NEC, Katie Daugherty, RN, NEC, Kay Weinkam, RN, NEC, Kelly McHan, RN, NEC, Miyo Minato, RN, NEC, Shelly Ward RN, NEC, Leslie Moody RN, NEC, Carol Mackay, MN, RN, NEC, Bobbie Pierce, Licensing Manager, Kathy Hodge Enforcement, Julie Campbell-Warnock Research Program Specialist

Nancy Beecham, acting Chair opened the meeting shortly after 1:00 pm and the committee members introduced themselves.

10.0 Review and Approve Minutes:

- Ø November 16, 2010
- Ø September 22, 2010
- Ø July 13, 2010
- Ø May 18, 2010

MSC: Minutes were held over to the next committee meeting for approval.

10.1 A Report on the Institute of Medicine and Robert Wood Johnson Foundation Initiative on the Future of Nursing by Liana Orsolini-Hain, Ph.D., RN, CCRN, Committee Member

Dr. Liana M. Hain, Ph.D., is a committee member on the Robert Wood Johnson Foundation Initiative on the Future of Nursing. Dr. Hain is a full-time tenure track instructor at City College of San Francisco. She has more than 16 years of experience in associate's degree nursing education.

The following is an excerpt from the free summary, titled "The Future of Nursing: Leading Change, Advancing Health". The Committee's charge is to examine and produce recommendations related to the following issues, with the goal of identifying vital roles for nurses in designing and implementing a more effective and efficient health care system:

- Reconceptualizing the role of nurses within the context of the entire workforce, the shortage, societal issues, and current and future technology; and
- Expanding nursing faculty, increasing the capacity of nursing schools, and redesigning nursing education to assure that it can produce an adequate number of well prepared nurses able to meet current and future health care demands; and
- Examining innovative solutions related to health care delivery and health professional education focusing on nursing and delivery of nursing services; and
- Attracting and retaining will prepared nurses in multiple care settings, including acute, ambulatory, primary care, long term care, community and public health.

The link to the summary can be found at:
http://www.nap.edu/nap-cgi/report.cgi?record_id=12956&type=pdfxsum

10.2 Registered Nurse Advisories

- Abuse Reporting Requirements
- Background Checks for Student Clinical Placement
- California Nursing Practice Act
- Complaint Disclosure Policy
- Continuing Education for License Renewal
- Good Samaritan
- Interim Permittee
- Information About Medical Assistant
- License Information
- Nurse Practitioners & Nurse-Midwives - Supervision of Medical Assistants
- Residential Care for the Elderly Employee, RCFE, Training for Self-Administration of Medication
- Unlicensed Assistive Personnel
- Use of Title: Registered Nurse and Name Tags

10.3 Public Comment for Items Not on the Agenda

Submitted by:

_____
Janette E. Wackerly, MBA
Chair

Approved by:

_____
Kathrine Ware, MSN, RN, ANP-C

BOARD OF REGISTERED NURSING
Nursing Practice Committee
Agenda Item Summary

AGENDA ITEM: 10.1
DATE: January 5, 2011

ACTION REQUESTED: Report on the Goals and Objectives 2010

REQUESTED BY: Janette Wackerly, MBA, RN
Nursing Education Consultant

BACKGROUND:
Each year the Practice Committee reviews the goal achievement through committee activities and staff activities related to the goals.

NEXT STEP: Board

FINANCIAL IMPLICATIONS, IF ANY: None

PERSON TO CONTACT: Janette Wackerly, MBA, RN
Nursing Education Consultant

BOARD OF REGISTERED NURSING
NURSING PRACTICE COMMITTEE

REPORT GOALS AND OBJECTIVES 2010

GOAL 1 **In support of the consumer's right to quality care, identify and evaluate issues related to registered nursing tasks being performed by unlicensed assistive personnel.**

Objective 1.1 Take an active role in activities conducted by other agencies and organizations related to unlicensed assistive personnel.

Nursing Education Consultants respond frequently to telephone and e-mail questions regarding unlicensed practices. The NEC staff received and reviewed questions from acute care hospitals. In some instances questions arise when technicians by virtue of their job description are performing functions requiring a nursing license. The NEC provides explanation regarding RN scope of practice and refers to BPC §2725.3 functions performed by unlicensed personnel does **not** allow unlicensed personnel in acute care to perform licensed nursing functions. The person inquiring about RN scope of practice and unlicensed personnel functions is many times referred to the Department of Public Health, Licensing and Certification for follow up.

Other frequently asked questions are in regard to supervision of unlicensed assistive personnel or technicians performing assigned tasks. The RN is often times referred to the Standards of Competent Performance, CCR §1443.5 (4).

GOAL 2 **Promote patient safety as an essential and vital component of quality nursing care.**

Objective 2.1 Engage and dialogue with recognized national experts in supporting patient safety in what individuals and organizations have done and what remains to be done. For example just culture and root cause analysis, failure mode and effect analysis, human factor and systems factor.

At the February 24, 2010 Practice Committee meeting Suzanne Graham, PhD, RN, Director of Patient Safety, California Regions, Kaiser Permanent presented Managing Error in a Just Culture. A panel of representatives from Kaiser Permanente presented their work implementing Kaiser's Just Culture methodology. The Kaiser representatives included Anita Zunita, RN, MSN, Regional Executive Director Patient Care Services for Northern California and Judy Husted, RN, MS, Healthcare Administration, Director Patient Care Services, Regional Operations Southern California Kaiser Foundation

Hospital and Health Plans. Also in attendance were representatives from the United Nurses Association of California/United Health Care Professionals were Barbara l. Blake, RN, UNAC/UHCP and Denise Duncan, RN, UNAC/UHCP. The representative described how they participate in the "just culture environment" at Kaiser Southern California.

Objective 2.2 Monitor patient and resident safety activities as a component of quality nursing care such as health care errors, competency, patient outcomes, stakeholders, nursing shortage, ethics, lifelong learning, nursing standards, licensure, safety legislation, magnet hospitals.

BRN staff working with Joanne Spetz, PhD, University of California, San Francisco Center for Health Professions are working to complete a BRN report on the study of California RNs who either began or extended probation in 2004-2005. The study is based on one published work by the American Journal of Nursing, published in 2009. A 29-item data extraction template was used to obtain data on the characteristics of the disciplined nurses, their employment settings, board actions, and remediation outcomes. The plan is for Joan Spetz to present the study outcomes at the Board's February 2011 meeting.

At the November 16, 2010 Practice Committee meeting a presentation was given by Liana Orsolilini-Hain PhD, RN, CCRN, committee member on the Robert Wood Johnson Foundation Initiative. Ms. Oroslilini-Hain gave an overview of the Institute of Medicine and Robert Wood Johnson Foundation Initiative on the Future of Nursing. The Committee's charge is to examine and produce recommendations related to the goal of identifying vital roles for nurses in designing and implementing a more effective and efficient health care system.

On November 30, 2010, the Practice Committee Chair and NEC staff participated in person and by webcast attended the California Awareness Meeting: Robert Wood Johnson Foundation Initiative on the Future of Nursing, Campaign for Action held at UCD Education building. Members of the California Regional Action Coalition, presenters and other participants were recognized for their thoughts, ideas, insights and other significant contributions. Stay informed website: www.thefutureofnursing.org

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GOAL 3 Develop and implement processes for the Board to interact with stakeholders to identify current trends and issues in nursing practice and the health care delivery system.

Objective 3.1 Actively participate with other public and private organizations and agencies involved with health care to identify common issues and to promote RN scope of practice consistent with the Nursing Practice Act and ensuring consumer safety.

Committee Liaison presenter at Asilomar COADN Conference April 23, 2010 BRN Udate: Current Issues and Trends. Audience was nursing program faculty and nursing administrators.

At the July 13, 2010 Practice Committee meeting Dr. Nancy Cowen MS, EdD, RN Director at Chabot College and Vicky Maryatt, MSN, RN, President of the Northern California Associate Degree Nursing Director's group provided results of a survey of northern Associate Degree Nursing Programs regarding barriers to nursing student clinical practice. In spring 2010, many northern nursing programs were notified of loss of clinical placements in acute care units, OB, and mental health, medical/surgical and geriatrics nursing units. At the time of the July 13, 2010 Practice Committee meeting clinical placements for fall have not been confirmed. An increasing barrier to clinical nursing for students involves restrictions on performing glucometer testing (blood glucose), access to electronic medication record, and limiting Bar Code Medication Administration. Faculties are experiencing changes in acute care where nursing students learning opportunities have been declining is some hospitals. Due in part to this report of the northern ADN directors and reports at Practice Committee, the Annual School Survey will survey these barriers to student nurse practice and provide a more comprehensive report The Annual School Survey results should be available in early 2011.

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Committee liaison presented on RN Scope of Practice Issues at Kaiser Permanentee educational program for Triage/Advice Nursing September 9 and 16, 2010 in Lafayette California.

Nursing Education Consultants attended Magic in Teaching, a two day educational program, produced by California Institute for Nursing and Health Care and the BRN, October 20 and 21, 2010 in San Francisco.

GOAL 4 **Identify and implement strategies to impact identified trends and issues.**

Objective 4.2 Collaborate with the Education/Licensing Committee on educational issues/trends and the Legislative Committee on legislation pertaining to nursing practice.

At the February 24, 2010, the Practice Committee reviewed advisories based on Legislation Enacted in 2008-2009 Session.

(1) SB 819 (McCloud, Omnibus Bill) added Section 2835.7 To Business and Professions Code authorizing nurse practitioners in approved standardized procedures to order durable medical equipment, certify disability after performance of a physical examination and collaboration with the

physician, and home health services after consultation with the treating physician.

(2) AB 1116 (Carter, 509) Section 1638.2 & Section 2259.8 enacts to Business and Professions Code Cosmetic Surgery, the Donda West Law. The patient receives an appropriate physical examination by a physician, **nurse practitioner,** physician assistant, dentist and the examination includes a medical history. The examination may be performed in advance of the surgery but not more than 30 days.

(3) SB 112 (Oropeza, Chapter 559) Hemodialysis Technicians. Implementing federal Medicare by April 15, 2010 requirement for hemodialysis technician certification to meet certain educational requirements and successfully pass a standardized test.

Objective 4.3 Review and revise current BRN advisory statements and recommend new advisory statements as needed to clarify standards of nursing practice.

At the November 16, 2010 Practice Committee meeting the members reviewed 13 nursing advisories and forwarded those 13 advisories for Board approval on November 17, 2010. The advisories were approved by the Board and are as follows: Abuse Reporting Requirements, Background Checks for Student Clinical Placement, California Nursing Practice Act, Complaint Disclosure Policy, Continuing Education for License Renewal, Good Samaritan, Interim Permittee, Information about Medical Assistants, License Information, Nurse Practitioners and Nurse-Midwives- Supervision of Medical Assistants, Residential Care for the Elderly Employee, RCFE, Training for Self-Administration of Medication, Unlicensed Assistive Personnel, and Use the title: Registered Nurse.

GOAL 5 **Develop and implement processes for the Board to interact with stakeholders to identify and evaluate issues related to advanced practice nursing and to promote maximum utilization of advanced practice nursing.**

Objective 5.1 Support and promote full utilization of advanced practice nurses.

At the February 24, 2010 Practice Committee meeting two nurse practitioner advisories were revised based on enacted Legislation 2008-2009, adding to Business and Professions Code, Section 2835.7. Authorized Standardized Procedure were reviewed and forwarded to the Board for approval. The Board approved the advisories and they are as follows:

(1) Nurse Practitioner: Laws and Regulations
(2) General Information: Nurse Practitioner Practice

Objective 5.2 Monitor trends and growing opportunities for advanced practice nursing in areas of health promotion, prevention and managing patients through the continuum of care.

BRN staff, APRN practitioners, and Joanne Spetz and other research staff from the University of California, San Francisco Center for Health Professions developed a survey tool to be sent to Nurse Practitioners, Nurse-Midwives and Clinical Nurse Specialist to collect data on demographics, education, employment, practice, and standardized procedures used by APRNs in California. There has not been much data collected from these APRNs nationally or in other states. The results of the survey will be available summer 2011.

Objective 5.3 Actively participate with organizations and agencies focusing on advanced practice nursing.

Staff participates with APRN Networking Group via telephone with the National Counsel State Board of Nursing.

Objective 5.4 In collaboration with the Education/Licensing Committee remain actively involved in facilitating communication and work in progress for education/certification function and communication with advanced practice educational program directors, professional organizations, state agencies and other groups.

At the May 18, 2010, Practice Committee meeting, Colleen Keenan PhD, RN, CANP Board of Director, Chair Practice Committee presented the APRN Regulatory Consensus: Issues for Nurse Practitioners.

BOARD OF REGISTERED NURSING
NURSING PRACTICE COMMITTEE

2010/2011 GOALS AND OBJECTIVES

GOAL 1 **In support of the consumer's right to quality care, identify and evaluate issues related to registered nursing tasks being performed by unlicensed assistive personnel.**

Objective 1.1 Take an active role in activities conducted by other agencies and organizations related to unlicensed assistive personnel.

GOAL 2 **Promote patient safety as an essential and vital component of quality nursing care.**

Objective 2.1 Engage and dialogue with recognized national experts in supporting patient safety in what individuals and organizations have done and what remains to be done. For example just culture and root cause analysis, failure mode and effect analysis, human factor and systems factor.

Objective 2.2 Monitor patient and resident safety activities as a component of quality nursing care such as health care errors, competency, patient outcomes, stakeholders, nursing shortage, ethics, lifelong learning, nursing standards, licensure, safety legislation, magnet hospitals.

GOAL 3 **Develop and implement processes for the Board to interact with stakeholders to identify current trends and issues in nursing practice and the health care delivery system.**

Objective 3.1 Actively participate with other public and private organizations and agencies involved with health care to identify common issues and to promote RN scope of practice consistent with the Nursing Practice Act and ensuring consumer safety.

GOAL 4 **Identify and implement strategies to impact identified trends and issues.**

Objective 4.1 Provide timely written and/or verbal input on proposed regulations related to health care policies affecting nursing care.

Objective 4.2 Collaborate with the Education/Licensing Committee on educational issues/trends and the Legislative Committee on legislation pertaining to nursing practice.

Objective 4.3 Review and revise current BRN advisory statements and recommend new advisory statements as needed to clarify standards of nursing practice.

GOAL 5	**Develop and implement processes for the Board to interact with stakeholders to identify and evaluate issues related to advanced practice nursing and to promote maximum utilization of advanced practice nursing.**
Objective 5.1	Support and promote full utilization of advanced practice nurses.
Objective 5.2	Monitor trends and growing opportunities for advanced practice nursing in areas of health promotion, prevention and managing patients through the continuum of care.
Objective 5.3	Actively participate with organizations and agencies focusing on advanced practice nursing.
Objective 5.4	In collaboration with the Education/Licensing Committee remain actively involved in facilitating communication and work in progress for education/certification function and communication with advanced practice educational program directors, professional organizations, state agencies and other groups.

BOARD OF REGISTERED NURSING
Nursing Practice Committee
Agenda Item Summary

AGENDA ITEM: 10.2
DATE: January 5, 2011

ACTION REQUESTED: Registered Nurse Advisories

REQUESTED BY: Janette Wackerly, MBA, RN
Nursing Education Consultant

BACKGROUND:
Registered nurse advisories are available at www.rn.ca.gov. When using the BRN home page, locate the cursor on left hand side of page, titled "Practice Information." Then locate the cursor over "registered nurse" for a listing of advisories.

The liaison to the Practice Committee with assistance from board staff has been updating BRN advisories utilizing the California Nursing Practice Act with Regulations and Related Statues, 2010 Edition and California Law found at www.leginfo.ca.gov as resources.

With Board approval, the following advisories will be posted to the BRN website:

- Abandonment of Patients
- An Explanation of the Scope of RN Practice Including Standardized Procedures
- Complementary and Alternative Therapies in Registered Nursing Practice
- Nursing Student Workers
- RN Tele-Nursing and Telephone Triage
- Reproductive Privacy Act
- Standardized Procedures Guidelines
- Standards of Competent Performance
- Supervisor's Responsibility
- The RN as the First Assistant to the Surgeon

NEXT STEPS: **Board**

FISCAL IMPLICATIONS, IF ANY: **None**

PERSON(S) TO CONTACT: Janette Wackerly, MBA, RN
Nursing Education Consultant

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Louise R. Bailey, M.Ed., RN Executive Officer

ABANDONMENT OF PATIENTS

Inquiries have been received by the Board of Registered Nursing (BRN) regarding which actions by a nurse constitute patient abandonment and thus may lead to discipline against a nurse's license.

For patient abandonment to occur, the nurse must:

a) Have first **accepted** the patient assignment, thus establishing a nurse-patient relationship, and then

b) **Severed** that nurse-patient relationship without giving reasonable notice to the appropriate person (e.g., supervisor, patient) so that arrangements can be made for continuation of nursing care by others.

A nurse-patient relationship begins when responsibility for nursing care of a patient is accepted by the nurse. Failure to notify the employing agency that the nurse will not appear to work an assigned shift is not considered patient abandonment by the BRN, nor is refusal to accept an assignment considered patient abandonment. Once the nurse has accepted responsibility for nursing care of a patient, severing of the nurse-patient relationship without reasonable notice may lead to discipline of a nurse's license.

RNs must exercise critical judgment regarding their individual ability to provide safe patient care when declining or accepting requests to work overtime. A fatigued and/or sleep deprived RN may have a diminished ability to provide safe, effective patient care. Refusal to work additional hours or shifts would not be considered patient abandonment by the BRN.

The RN who follows the above BRN advisory statement will not be considered to have abandoned the patient for purposes of Board disciplinary action. However, it should be noted that the BRN has no jurisdiction over employment and contract issues.

Medical Abandonment Law & Legal Definition

Medical abandonment results when the caregiver-patient relationship is terminated without making reasonable arrangements with an appropriate person so that care by others can be continued. An example of a legal definition states as follows:

"Abandoning or neglecting a patient or client under and in need of immediate professional care, without making reasonable arrangements for the continuation of such care, or abandoning a professional employment by a group practice, hospital, clinic or other health care facility, without reasonable notice and under circumstances which seriously impair the delivery of professional care to patients or clients."

Some of the factors considered include:

- Did the caregiver accept the patient assignment, creating a caregiver-patient relationship?
- Did the caregiver provide reasonable notice before terminating the caregiver-patient relationship?
- Could reasonable arrangements have been made for continuation of care by others when proper notification was given?

In most cases, the following situations are not examples of abandonment:

- Refusing to accept responsibility for a patient assignment(s) when the caregiver has given reasonable notice to the proper agent that the nurse lacks competence to carry out the assignment.
- Refusing the assignment of a double shift or additional hours beyond the posted work schedule when proper notification has been given.

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AN EXPLANATION OF THE SCOPE OF RN PRACTICE INCLUDING STANDARDIZED PROCEDURES

The Legislature, in its 1973-74 session, amended Section 2725 of the Nursing Practice Act (NPA), amplifying the role of the registered nurse and outlining activities which comprise the practice of nursing.

LEGISLATIVE INTENT

The Legislature recognized that nursing is a dynamic field, continually evolving to include more sophisticated patient care activities. It declared its intent to recognize the existence of **overlapping functions** between physicians and registered nurses and to permit **additional such sharing** and to provide **clear legal authority** for those functions and procedures which have common acceptance and usage. Prior to this, nurses had been educated to assume advanced roles, and demonstration projects had proven their ability to do this safely and effectively. Thus, legal amplification of the role paralleled the readiness of nurses to assume the role and recognized that many were already functioning in an expanded role.

SCOPES OF PRACTICE

A knowledge of the respective scopes of practice of registered nurses and physicians is important in determining **which activities overlap** medical practice and therefore require standardized procedures. Failure to distinguish nursing practice from medical practice may result in the limitation of the registered nurse's practice and the development of unnecessary standardized procedures. Registered nurses are cautioned not to confuse nursing policies and procedures with standardized procedures.

1. Scope of Registered Nursing Practice

The activities comprising the practice of nursing are outlined in the Nursing Practice Act, Business and Professions Code Section 2725. A broad, all inclusive definition states that the practice of nursing means those functions, including basic health care, which help people cope with difficulties in daily living which are associated with their actual or potential health or illness problems, or the treatment thereof, which require a substantial amount of scientific knowledge or technical skill.

In Section 2725(a), the Legislature expressly declared its intent to provide clear legal authority for functions and procedures which have common acceptance and usage. Registered nurses must recognize that the application of nursing process functions is common nursing practice which **does not** require a standardized procedure. Nursing practice is divided into three types of functions, which are described below.

A. Independent Functions

Subsection (b)(1) of Section 2725, authorizes direct and indirect patient care services that insure the safety, comfort, personal hygiene and protection of patients, and the performance of disease prevention and restorative measures. Indirect services include delegation and supervision of patient care activities performed by subordinates.

Subsection (b)(3) of Section 2725, specifies that the performance of skin tests, immunization techniques and withdrawal of human blood from veins and arteries is included in the practice of nursing.

Subsection (b)(4) of Section 2725, authorizes observation of signs and symptoms of illness, reactions to treatment, general behavior, or general physical condition and determination of whether these exhibit abnormal characteristics; and based on this determination, the implementation of appropriate reporting or referral, or the initiation of emergency procedures. These independent nursing functions have long been an important focus of nursing education, and an implied responsibility of the registered nurse.

B. Dependent Functions

Subsection (b)(2) of Section 2725, authorizes direct and indirect patient care services, including, but not limited to, the administration of medications and therapeutic agents necessary to implement a treatment, disease prevention, or rehabilitative regimen ordered by and within the scope of licensure of a physician, dentist, podiatrist or clinical psychologist.

C. Interdependent Functions

Subsection (b)(4) of Section 2725, authorizes the nurse to implement appropriate standardized procedures or changes in treatment regimen in accordance with standardized procedures after observing signs and symptoms of illness, reactions to treatment, general behavior, or general physical condition, and determining that these exhibit abnormal characteristics. These activities overlap the practice of medicine and may require adherence to a standardized procedure when it is the nurse who determines that they are to be undertaken.

2. Scope of Medical Practice

The Medical Practice Act authorizes physicians **to diagnose** mental and physical conditions, **to use drugs in or** upon human beings, **to sever or penetrate the tissues** of human beings and **to use other methods** in the treatment of diseases, injuries, deformities or other physical or mental conditions. As a general guide, the performance of any of these by a registered nurse requires a standardized procedure; however, activities within each of these categories have already become common nursing practice and therefore do not require standardized procedures; for example, the administration of medication by injection requires penetration of human tissue, and registered nurses have performed this function through the years.

In Section 2725(a), the Legislature referred to the dynamic quality of the nursing profession. This means, among other things, that some functions which today are considered medical practice will become common nursing practice and no longer require standardized procedures. Examples of medical functions which have evolved into common nursing functions are the measurement of cardiac output pressures, and the insertion of PICC lines.

STANDARDIZED PROCEDURES FOR MEDICAL FUNCTIONS

The means designated to authorize performance of a medical function by a registered nurse is a standardized procedure developed through collaboration among registered nurses, physicians and administrators in the **organized health care system** in which it is to be used. Because of this interdisciplinary collaboration, there is accountability on several levels for the activities to be performed by the registered nurse. Section 2725(a) defines "organized health care systems" to include, but are not limited to, licensed health facilities, clinics, home health agencies, physicians' offices, and public or community health services.

GUIDELINES FOR DEVELOPING STANDARDIZED PROCEDURES

Standardized procedures are **not subject to prior approval** by the boards that regulate nursing and medicine; however, they must be developed according to the following guidelines which were jointly promulgated by the Board of Registered Nursing and the Medical Board of California. (Board of Registered Nursing, Title 16, California Code of Regulations (CCR) section 1474; Medical Board of California, Title 16, CCR Section 1379.)

(a) Standardized procedures shall include a written description of the method used in developing and approving them and any revision thereof.

(b) Each standardized procedure shall:

(1) **Be in writing, dated and signed by the organized health care system** personnel authorized to approve it.

(2) Specify **which standardized procedure functions** registered nurses may perform and under what circumstances.

(3) State any specific **requirements which are to be followed** by registered nurses in performing particular standardized procedure functions.

(4) Specify any **experience, training and/or education** requirements for performance of standardized procedure functions.

(5) Establish a method for initial and continuing **evaluation** of the competence of those registered nurses authorized to perform standardized procedure functions.

(6) Provide for a method of maintaining a written record of those **persons authorized to perform** standardized procedure functions.

(7) Specify the scope of **supervision** required for performance of standardized procedure functions, for example, telephone contact with the physician.

(8) Set forth any specialized circumstances under which the registered nurse is to immediately **communicate with a patient's physician** concerning the patient's condition.

(9) State the limitations on **settings**, if any, in which standardized procedure functions may be performed.

(10) Specify patient **record-keeping** requirements.

(11) Provide for a method of **periodic review** of the standardized procedures.

An additional safeguard for the consumer is provided by steps four and five of the guidelines which, together, form a **requirement that the nurse be currently capable** to perform the procedure. The registered nurse who undertakes a procedure without the competence to do so is grossly negligent and subject to discipline by the Board of Registered Nursing.

SUMMARY OF RN FUNCTIONS UNDER STANDARDIZED PROCEDURES
Registered nursing functions under standardized procedures may be summarized as follows:

WHO: the registered nurse

WHAT: may perform a medical function beyond the usual scope of RN practice

HOW: in accord with a written standardized procedure developed by nursing, medicine and administration

WHERE: in an organized health care system

WHEN: after the RN has been evaluated and approved as having met the education and experience requirements specified in the procedure

WHY: because the standardized procedure authorizes the RN to exceed the usual scope of RN practice

TO DETERMINE IF A STANDARDIZED PROCEDURE IS REQUIRED

Ask each question below in the order presented. Continue only until your answer points to "S.P. required," or to "S.P. not required."

1. Is the function commonly recognized as nursing practice?

   NO **YES ⇒ S.P. not required**
   ⇓

2. Is it the standard of practice in the community that RNs perform this function in the clinical area for which it is being considered?

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3. Does the function require the nurse to:
   Diagnose disease,
   Prescribe medicine or treatment, or
   Penetrate or sever tissue?

   NO **YES ⇒ S.P. required**
   ⇓

4. Does safe performance of the function require judgment based on medical knowledge beyond that usually possessed by the competent RN in the area for which it is being considered?

   NO **YES ⇒ S.P. required**
   ⇓

   S.P. not required

WHO DEVELOPS STANDARDIZED PROCEDURES?

1. Organized Health Care Systems →
   - Health Facilities licensed by Dept. of Public Health
   - Health Facilities not licensed (CCR 1470): Clinics, Home Health Agencies, Physicians Offices, Public or Community Health Services

2. Collaborating:

   Administrators, and Health Care Professionals, including →
   - REGISTERED NURSES
   - PHYSICIANS

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In Section 2725(a), the Legislature expressly declared its intent to provide clear legal authority for functions and procedures which have common acceptance and usage. Registered nurses must recognize that the application of nursing process functions is common nursing practice which **does not** require a standardized procedure. Nursing practice is divided into three types of functions, which are described below.

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2. Scope of Medical Practice
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STANDARDIZED PROCEDURES FOR MEDICAL FUNCTIONS
The means designated to authorize performance of a medical function by a registered nurse is a standardized procedure developed through collaboration among registered nurses, physicians and administrators in the **organized health care system** in which it is to be used. Because of this interdisciplinary collaboration, there is accountability on several levels for the activities to be performed by the registered nurse. Section 2725(a) defines "organized health care systems" to include, but are not limited to, licensed health facilities, clinics, home health agencies, physicians' offices, and public or community health services.

GUIDELINES FOR DEVELOPING STANDARDIZED PROCEDURES
Standardized procedures are **not subject to prior approval** by the boards that regulate nursing and medicine; however, they must be developed according to the following guidelines which were jointly promulgated by the Board of Registered Nursing and the Medical Board of California. (Board of Registered Nursing, Title 16, California Code of Regulations (CCR) section 1474; Medical Board of California, Title 16, CCR Section 1379.)

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(2) Specify **which standardized procedure functions** registered nurses may perform and under what circumstances.

(3) State any specific **requirements which are to be followed** by registered nurses in performing particular standardized procedure functions.

(4) Specify any **experience, training and/or education** requirements for performance of standardized procedure functions.

(5) Establish a method for initial and continuing **evaluation** of the competence of those registered nurses authorized to perform standardized procedure functions.

(6) Provide for a method of maintaining a written record of those **persons authorized to perform** standardized procedure functions.

(7) Specify the scope of **supervision** required for performance of standardized procedure functions, for example, telephone contact with the physician.

(8) Set forth any specialized circumstances under which the registered nurse is to immediately **communicate with a patient's physician** concerning the patient's condition.

(9) State the limitations on **settings**, if any, in which standardized procedure functions may be performed.

(10) Specify patient **record-keeping** requirements.

(11) Provide for a method of **periodic review** of the standardized procedures.

An additional safeguard for the consumer is provided by steps four and five of the guidelines which, together, form a **requirement that the nurse be currently capable** to perform the procedure. The registered nurse who undertakes a procedure without the competence to do so is grossly negligent and subject to discipline by the Board of Registered Nursing.

~~**Standardized procedures which reference textbooks and other written resources in order to meet the requirements of Title 16, CCR Section 1474 (3), must include book (specify edition) or article title, page numbers and sections. Additionally, the standards of care established by the sources must be reviewed and authorized by the registered nurse, physician and administrator in the practice setting. A formulary may be developed and attached to the standardized procedure. Regardless of format used, whether a process protocol or disease-specific, the standardized procedure must include all eleven required elements as outlined in Title 16, CCR Section 1474.**~~

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HOW: in accord with a written standardized procedure developed by nursing, medicine and administration

WHERE: in an organized health care system

WHEN: after the RN has been evaluated and approved as having met the education and experience requirements specified in the procedure

WHY: because the standardized procedure authorizes the RN to exceed the usual scope of RN practice

~~**STANDARDIZED PROCEDURE EXAMPLES**~~

~~The attached three example formats (Example A, a process protocol, Example B, a disease specific, and Example C, a procedure specific standardized procedure), conform to the guidelines and are adopted from existing practice protocols for standardized procedures and may be used as a guide in developing one's own standardized procedures.~~

~~The Board of Registered Nursing does not recommend or endorse the medical management of these example protocols.~~

TO DETERMINE IF A STANDARDIZED PROCEDURE IS REQUIRED

Ask each question below in the order presented. Continue only until your answer points to "S.P. required," or to "S.P. not required."

1. Is the function commonly recognized as nursing practice?

   NO **YES ⇒ S.P. not required**
   ⇓

2. Is it the standard of practice in the community that RNs perform this function in the clinical area for which it is being considered?

   NO **YES ⇒ S.P. not required**
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3. Does the function require the nurse to:
   Diagnose disease,
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   ⇓

4. Does safe performance of the function require judgment based on medical knowledge beyond that usually possessed by the competent RN in the area for which it is being considered?

   NO **YES ⇒ S.P. required**
   ⇓

   S.P. not required

WHO DEVELOPS STANDARDIZED PROCEDURES?

1. Organized Health Care Systems → ~~License by DHS~~
   → ~~Not licensed by DHS~~

2. Collaborating:

   Administrators, and Health Care Professionals, including → REGISTERED NURSES
   → PHYSICIANS

SUGGESTED FORMAT FOR STANDARDIZED PROCEDURES

I. POLICY

1. Function(s): (2)*
2. Circumstances under which R.N. may perform function: (2)
   a. Setting (9)
   b. Supervision (7)
   c. Patient Conditions
   d. Other

II. PROTOCOL (3)

1. Definitions
2. Data base
   a. Subjective
   b. Objective
3. Diagnosis
4. Plan
   a. Treatment
   b. Patient conditions requiring consultation (8)
   c. Education - patient/family
   d. Follow up
5. Record keeping (10)

III. REQUIREMENTS FOR REGISTERED NURSE: (4)(5)

1. Education
2. Training
3. Experience
4. Other
5. Initial Evaluation
6. On-going Evaluation

IV. DEVELOPMENT AND APPROVAL OF THE STANDARDIZED PROCEDURE

1. Method: (Title 16, CCR Section 1474(a))
2. Review schedule (11)
3. Signatures of authorized personnel approving the standardized procedure, and dates: (1)
   a. Nursing
   b. Medicine
   c. Administration

V. REGISTERED NURSES AUTHORIZED TO PERFORM PROCEDURE AND DATES (6)

1.
2.

***Numbers in parentheses correspond to Board of Registered Nursing guideline numbers in Title 16, CCR Section 1474.**

EXAMPLE A (Process Protocol)

The Board of Registered Nursing does not recommend or endorse the medical management of this sample standardized procedure. It is intended as a guide for format purposes only.

Standardized Procedures

General Policy Component

I. Development and Review

A. All standardized procedures are developed collaboratively and approved by the Interdisciplinary Practice Committee (IDPC) whose membership consists of nurse practitioners, nurse-midwives, nurses, physicians, and administrators and must conform to all 11 steps of the standardized procedure guidelines as specified in Title 16, CCR Section 1474.

B. All standardized procedures are to be kept in a manual which includes dated, signed approval sheets of the persons covered by the standardized procedures.

C. All standardized procedures are to be reviewed every three years and as practice changes by the IDPC.

D. All changes or additions to the standardized procedures are to be approved by the IDPC accompanied by a dated and signed approval sheet.

II. Scope and Setting of Practice

A. Nurses may perform the following functions within their training specialty area and consistent with their experience and credentialing: assessment, management, and treatment of episodic illnesses, chronic illness, contraception, and the common nursing functions of health promotion, and general evaluation of health status (including but not limited to ordering laboratory procedures, x-rays, and physical therapies, recommending diets, and referring to Specialty Clinics when indicated).

B. Standardized procedure functions, such as managing medication regimens, are to be performed in (list area, i.e., short appointment clinic). Consulting physicians are available to the nurses in person or by telephone.

C. Physician consultation is to be obtained as specified in the individual protocols and under the following circumstances:

1. Emergent conditions requiring prompt medical intervention after initial stabilizing care has been started.

2. Acute decompensation of patient situation.

3. Problem which is not resolving as anticipated.

4. History, physical, or lab findings inconsistent with the clinical picture.

5. Upon request of patient, nurse, or supervising physician.

III. Qualifications and Evaluations

A. Each nurse performing standardized procedure functions must have a current California registered nursing license, be a graduate of an approved Nurse Practitioner or Nurse-midwifery program, and be certified as a Nurse Practitioner or Nurse-Midwife by the California Board of Registered Nursing.

B. Evaluation of nurses' competence in performance of standardized procedure functions will be done in the following manner:

1. **Initial:** at 3 months, 6 months and 12 months by the nurse manager through feedback from colleagues, physicians, and chart review during performance period being evaluated.

2. **Routine:** annually after the first year by the nurse manager through feedback from colleagues, physicians, and chart review.

3. **Follow-up:** areas requiring increased proficiency as determined by the initial or routine evaluation will be re-evaluated by the nurse manager at appropriate intervals until acceptable skill level is achieved, e.g. direct supervision.

IV. Authorized Nurse Practitioners, Nurse-Midwives

List each

V. Protocols

The standardized procedure protocols developed for use by the nurses are designed to describe the steps of medical care for given patient situations. They are to be used in the following circumstances: management of acute/episodic conditions, trauma, chronic conditions, infectious disease contacts, routine gynecological problems, contraception, health promotion exams, and ordering of medications.

STANDARDIZED PROCEDURES
FOR NURSE PRACTITIONERS
AND NURSE-MIDWIVES

Revised Spring 1994

Interdisciplinary Practice Committee

(signature) _____		(signature) _____	
full name & title	date	full name & title	date
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STANDARDIZED PROCEDURES

Management of Common Primary Care Conditions

I. Policy

A. As described in the General Policy Component.

B. Covers only those registered nurses as identified in General Policy Component.

II. Protocol

A. **Definition:** This protocol covers the management of common primary care conditions seen in the outpatient setting, such as eczema, headaches, acne, fatigue syndromes, allergic rhinitis, and low pain.

B. **Database** - Nursing Practice
(Perform usual total nursing assessment to establish data base).

C. **Treatment Plan** - Medical Regimen

1. **Diagnosis**
   a. Most consistent with subjective and objective findings expected by patient. If diagnosis is not clear, assessment to level of surety plus differential diagnosis.
   b. Assessment of status of disease process when appropriate.

2. **Treatment** - (Common nursing functions)
   a. Further lab or other studies as appropriate.
   b. Physical therapy if appropriate.
   c. Diet and exercise prescription as indicated by disease process and patient condition.
   d. Patient education and counseling appropriate to the disease process.
   e. Follow-up appointments for further evaluation and treatment if indicated.
   f. Consultation and referral as appropriate.
3. **Physician Consultation:** As described in the General Policy Component.

4. **Referral to Physician or Specialty Clinic:** Conditions for which the diagnosis and/or treatment are beyond the scope of the nurse's knowledge and/or skills, or for those conditions that require consultation.

5. **Furnishing Medications** - (Medical Regimen)
Follow furnishing protocol, utilizing formulary.

PROTOCOL: DRUGS AND DEVICES

Definition: This protocol covers the management of drugs and devices for women of all ages presenting to clinic. The nurse practitioner or nurse-midwife may initiate, alter, discontinue, and renew medication included on, but not limited to the attached formulary. All Schedule I and Schedule II drugs are excluded.

Subjective Data: Subjective information will include but is not limited to:

1. Relevant health history to warrant the use of the drug or device.
2. No allergic history specific to the drug or device.
3. No personal and/or family history which is an absolute contraindication to use the drug or device.

Objective Data: Objective information will include but is not limited to:

1. Physical examination appropriate to warrant the use of the drug or device.
2. Laboratory tests or procedures to indicate/contraindicate use of drug or device if necessary.

Assessment: Subjective and objective information consistent for the use of the drug or device. No absolute contraindications of the use of the drug or device.

Plan: Plan of care to monitor effectiveness of any medication or device.

Patient Education: Provide the client with information and counseling in regard to the drug or device. Caution client on pertinent side effects or complications with chosen drug or device.

Consultation and/or Referral: Non-responsiveness to appropriate therapy and/or unusual or unexpected side effects and as indicated in general policy statement.

REFERENCES: PDR '94 50th Edition (list page)
Primary Care Medicine, 3rd Edition, Chapter (list), pp. (list)
Handbook of Gynecology and Obstetrics, 3rd Edition, Chapter (list), pp. (list)

FORMULARY

To include but not limited to those medications listed below:

Antibiotic:	Ampicillin, Penicillin, Amoxicillin, Dicloxacillin, Augmentin, Keflex, Tetracycline, Noroxin, Minocin, Vibramycin, Benemid, Macrodantin, Erythromycin, Rocephin, Gantrisin, Trimethoprim/sulfamethoxazole, Nitrofurantoin, Nalidixic acid.
Antidiarrheal:	Imodium, Donnagel
Antiemetic:	Trans-derm V, Compazine, Phenergan, Tigan
Antifungal:	Mycostatin oral suspension/tablets, Nizoral, Monistat, Femstat, Terazol, Gyne-Lotrimin
Antiviral:	Zovirax ointment/capsules, Podophyllin 25-75%, Trichloroacetic acid
Antiparasite:	Flagyl/Protostat, Kwell lotion/shampoo, RID lotion, Eurax cream
Biologic:	RhoGAM, HypRho-D
Chemotherapeutic:	5FU for vaginal or vulvar use
Devices:	Diaphragm, cervical cap, IUD, pessary, Norplant
Diuretic:	Spironolactone, Dyazide
Hormone:	All oral contraceptives, progesterone preparations, Estrogen (Premarin, Estinyl, Delestrogen, Estrovis, Estrace), Estraderm, Protestins (Aygestin, Provera, Micronor, Nor QD, Ovrette), Estrogen vaginal creams (Premarin, Estrace)
Local anesthetic:	Xylocaine Jel 2%, Xylocaine 1% injection

Nonsteroidal Anti-inflammatory: Anaprox, Anaprox DS, Suprol, Motrin, Ponstel, Naprosyn, Rufen

Over the counter:	Spermicidal agents, cold & cough preparations (non-narcotic), laxatives, stool softeners, antacids, antiflatulents, analgesics, prostaglandin inhibitors, topicals, vitamin/mineral, antihistamines, decongestants, hemorrhoidal/antidiarrheal.
Rectal:	Anusol HC, Wyanoids
Thyroid:	Synthroid, Armour thyroid tablets
Urinary analgesic:	Pyridium
Vaginal:	All appropriate antifungals, Aminocervical cream, Acijel, Betadine, Triple Sulfa cream, Estrogen cream.
Vitamin/Mineral:	Prenatal vitamins, iron pill

EXAMPLE B (Disease Specific)

The Board of Registered Nursing does not recommend or endorse the medical management of this sample standardized procedure. It is intended as a guide for format purposes only.

STANDARDIZED PROCEDURE

DEPARTMENT:_____ FACILITY:_____

POLICY

I. FUNCTIONS NURSE PRACTITIONERS MAY PERFORM:

Provide care for patients with acute conditions as covered in attached protocol (see sample attached) and furnish non-controlled drugs and devices to essentially healthy patients.

II. CIRCUMSTANCES UNDER WHICH NURSE PRACTITIONERS MAY PERFORM THESE FUNCTIONS:

A. May furnish non-controlled drugs and devices under standardized procedures under the supervision of a designated physician (or designee).

B. Applies to nurse practitioners working in (indicate departments involved).

III. EXPERIENCE, TRAINING AND/OR EDUCATION REQUIRED OF THE NURSE PRACTITIONER:

Maintains a current California license to practice as an RN, is certified by the State of California as a Nurse Practitioner, has met all the requirements for and has a current Furnishing Number issued by the Board of Registered Nursing. Is oriented to the facility.

IV. METHOD OF INITIAL AND CONTINUED EVALUATION OF COMPETENCE:

General competency is initially evaluated during the probationary period through a proctoring process by the supervising physician. The registered nurse is assigned to and is supervised by a designated physician who is responsible to annually evaluate appropriateness of practice and clinical decision making. A QA review process is established to assure that compliance to standards relating to important aspects of care are maintained.

V. DOCUMENTATION

Documentation required is outlined in each protocol. Patient specific documentation is entered into the patient's medical record.

DEVELOPMENT AND APPROVAL
OF THE STANDARDIZED PROCEDURE

I. THIS STANDARDIZED PROCEDURE WAS:

Developed by the supervising physician, or designee, and the Nurse Practitioner. Approved by the department Chief, Director of Nursing Practice, Physician-in-Chief or designees, and Medical Group Administrator.

II. THIS STANDARDIZED PROCEDURE WILL BE REVIEWED AT LEAST ANNUALLY.

REVISION DATED _____ REVIEWED DATED _____
_____ _____
_____ _____

III. THE STANDARDIZED PROCEDURE WAS APPROVED BY:

MEDICINE _____ DATE_____
(Chief of Department)

MEDICINE _____ DATE_____
(PIC/Designee)

NURSING _____ DATE_____
(Director of Nursing Practice)

ADMINISTRATION _____ DATE_____
(Medical Group Administrator)

IV. PRACTITIONERS FUNCTION UNDER THIS STANDARDIZED PROCEDURE:

Current list of authorized personnel are on file in the office of the Medical Group Administrator and department manager.

PROTOCOLS (List those applicable)

I.E., Urinary Tract Infection (see attached).
Respiratory tract infection
Otitis Media
Vaginitis

References: List

URINARY TRACT INFECTION PROTOCOL: INITIAL VISIT

I. RATIONALE

This protocol will assist in the differentiation between pyelonephritis and urinary tract symptoms sufficiently to eradicate the symptoms per se rather than attempt to eradicate any bacteriuria that may or may not be present. The design of the protocol for UTI encompasses these principles.

II. SYMPTOMS

A. CYSTITIS

1. Female patients

Order a STAT CVMS UA for female patients with any of the following symptoms;

a. Dysuria
b. Frequency
c. Urgency
d. Inability to empty bladder completely

2. Male patients

Male patients with any of the above symptoms should be seen by an M.D., not by a NP, unless they have a urethral discharge (possible VD - follow VD protocol).

B. PYELONEPHRITIS

1. In addition to the above symptoms, patients with pyelonephritis may have:
   a. Fever greater than 100.0 F. or
   b. Flank pains, or
   c. Chills, or
   d. Nausea, vomiting or abdominal pain.
2. Continue with protocol through the physical exam with these patients, but then consult supervising physician before deciding on treatment.

III. HISTORY

A. Consult supervising physician if patient has:

1. A history of kidney problems, or
2. Is currently pregnant. To ascertain this, always ask for LMP date and record for all female patients.
3. Diabetes or insulin.
4. Three or more UTIs in past 12 months

B. Continue with UTI protocol, but also refer patient to GYN if history of:

1. Vaginal discharge, or
2. Perineal inflamation.

IV. PHYSICAL EXAM

A. Perform the following examinations:

1. Abdominal
2. CVA
3. Temperature

B. Consult supervising physician if findings of:

1. Fever greater than 100.0 F. or

2. CVA tenderness.

V. LAB TESTS

INITIAL URINALYSIS

A. Consult supervising physician if:
1. Casts
2. RBCs or protein are positive (without associated WBC abnormality).

B. If UA shows 10 or more WBCs/hpf and patient is symptomatic, give patient antibiotic prescription as described in the treatment section.

C. If UA revealed 0-10 WBCs, review symptoms. If the symptoms are definite and very severe, treat with antibiotics; if symptoms are vague and poorly defined, then give patient symptomatic treatment as described in the treatment section and consider referral to GYN for pelvic.

D. Should the initial UA be "positive": (defined in guidelines below), then give patient a repeat UA slip for the abnormality found with instructions to have that UA one week following completion of treatment.

Positive UA findings are defined as:

Casts: any except occasional hyaline or rare granular
RBCs > 3 (if not menstruating) and WBC < 5
Protein > trace and WBC < 5

VI. TREATMENT

ANTIBACTERIAL TREATMENT

To be given if initial UA reveals 10 or more WBC/hpf, or in any case where symptoms are severe, even if UA revealed, WBC/hpf.

A. Prescribe appropriate antibiotic drug (see p.6)

B. Instruct patient to call in if symptoms do not subside within 72 hours. If patient does call back, see p.7 for treatment failure instructions.

SYMPTOMATIC TREATMENT

To be given only if initial UA reveals, 10WBC/Hpf, and patient has minimal or uncertain symptoms. Consider GYN referral for pelvic.

A. Prescribe either Propantheline 15 mg #20 sig: 1-2 QID prn or Belladonna with Pb tabs #15, sig: 1 tab QID prn.
B. Instruct patient to call in if symptoms persist beyond 72 hours or if symptoms worsen at any time.

VII. REPEAT URINALYSIS (CVMS)

A. Consult supervising physician if UA shows casts.
B. If repeat UA confirms abnormality (protein and/or RBC as listed below) refer to Proteinuria and/or Hematuria protocols.

Positive UA findings are defined as:
Casts: any, except occasional hyaline or rare granular

RBCs >3 (if not menstruating) and WBC <5
Protein > trace and WBC <5

UTC PROTOCOL: ANTIBIOTIC TREATMENT

A. If organism found in patient's urine is not listed in the table below, consult supervising physician for treatment.

B. If this is the first antibiotic course (initial visit), assume E coli and use the first listed drug to which patient is not allergic, as listed for E coli in the drug table below.

C. If this is a second antibiotic course (treatment failure), go to the first drug for the organism listed that is not the same as that previously used and to which the patient is not allergic. If the patient is allergic to all drugs listed, consult supervising physician for treatment.

D. Prescribe according to the prescription table which follows:

1. If symptoms have been present within the past 48 hours, use 1 dose treatment.
2. If symptoms have been present longer than 48 hours, use 5-day treatment.
3. If symptoms persists after treatment with first drug, repeat UA and culture and consult supervising physician.

UTI PROTOCOL: TREATMENT FAILURE

If the patient calls in with persisted or recurrent symptoms after the first course of antibiotic treatment, obtain a CVMS urine specimen for UA and culture and sensitivity.

If the UA is negative, wait for the culture results before treating. If the UA is positive, treat with the next drug listed on the Antibiotic Prescription Table and review treatment choice when the culture and sensitivity results are available.

If culture is positive and patients symptoms are improving, stay with the same antibiotic. If not responding after 3 days, switch to a new antibiotic based on culture sensitivity.

Adapted from protocol developed by: _____, NP

_____, MD

(List names of nurse practitioners and physicians who developed the standardized procedure, including the protocol section).

ANTIBIOTIC PRESCRIPTION TABLE

ORGANISM	DRUG
E. Coli Proteus mirabilis	Septra DS, Amoxicillin Macrodantin, Keflex
Aerobacter Klebsiella	Septra DS, Macrodantin Keflex, Ciprofloxacin
Enterococcus	Ampicillin *Consult MD if allergic
Pseudomonas	Ciprofloxacin (Usually not seen in out-patient setting)

DOSAGES

SEPTRA DS	#3 PO at once or 1 bid x 5 days
AMOXICILLIN	500mg 3gms PO at once or 250mg 1 tid x 5 days
MACRODANTIN	100mg qid x 5 days
KEFLEX	250mg qid x 5 days
CIPROFLOXACIN	250mg qid x 5 days

EXAMPLE C (PROCEDURE SPECIFIC)

The Board of Registered Nursing does not recommend or endorse the medical management of this sample standardized procedure. It is intended as a guide for format purposes only.

STANDARDIZED PROCEDURE FOR DISPENSING BY REGISTERED NURSE

I. Policy

A. Drugs and devices listed in the agency formulary and prescribed by a lawfully authorized prescriber may be dispensed.
B. Setting - Adult Clinic.
C. Supervision - None required at the time of dispensing.

II. Protocol

A. Data Base
1. No patient or family history contraindications.
2. Agency required tests and procedures relative to the drug or device being dispensed demonstrate no contraindications.

B. Action
1. Affix label which contains information that follows.
a. Agency name, address and telephone number.
b. Patient's name.
c. Name of the prescriber and initials of the dispenser.
d. Date dispensed.
e. Trade or generic name of dispensed drug.
f. Quantity and strength of dispensed drug.
g. Directions for use of dispensed drug.
h. Expiration date of the drug's effectiveness.
2. Affix any appropriate auxiliary labels.
3. Use child proof containers.
4. Provide patient with appropriate information including:
- directions for taking the drug;
- what to do and whom to contact if side effects occur;
- common side effects;
- possible serious or harmful effects of the drug; and
- any manufacturer-prepared information required by the FDA.

C. Record Keeping - Document in the patient record:
1. Name, dosage, route and amount of the drug dispensed.
2. Lot number and manufacturer's name.
3. Other information, including patient instructions given.
4. Complete information in the pharmacy dispensing log.

D. Consultation - Contact the prescriber if the item is not listed in the agency formulary for RN dispensing or regarding contraindications.

III. Requirements for Registered Nurses

A. Education, training and experience: successful completion of the agency's in-service program on dispensing.

B. Initial evaluation: Demonstration of competency in skill performance to the satisfaction of the Pharmacy Director.

C. On-going evaluation - Monthly random record review by the pharmacist and an annual performance appraisal including observation of dispensing.

IV. Development and Approval of the Standardized Procedure

This standardized procedure was approved by the following:

NURSING_____ DATE _____

MEDICINE_____ DATE _____

PHARMACY_____ DATE _____

ADMINISTRATION _____ DATE _____

The standardized procedure will be reviewed annually.

V. RNs authorized to perform the procedure.

1. _____ DATE _____

2. _____ DATE _____

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COMPLEMENTARY AND ALTERNATIVE THERAPIES IN REGISTERED NURSING PRACTICE

Website: http://en.wikipedia.org/wiki/National_Center_for_Complementary_and_Alternative_Medicine

The competency of a registered nurse (RN) to perform the skills of complementary and alternative therapies begins with nursing education and ends with the safe nursing practice of those skills in such a way "that ensures the safety, comfort, personal hygiene, and protection of patients; and the performance of disease prevention and restorative measures" (B&P.§ 2725). A RN is deemed competent in complementary and alternative therapies when she/he consistently demonstrates the knowledge of complementary and alternative therapies, and performs these tasks safely.

History: Complementary and alternative therapies are based on the medical systems of ancient peoples, including Egyptians, Chinese, Asian Indians, Greeks, and Native Americans. Some therapies such as osteopathy and naturopathy have evolved in the United States over the past two centuries. Still other approaches, such as bioelectromagnetic applications, are on the frontier of current scientific knowledge and understanding.

Nursing Practice: The practice of nursing has traditionally espoused the concepts of systems, holistic, and humanistic theories. These theories are the essence of nursing practice and may include complementary and alternative therapies. Because of the theoretical congruence between nursing practice and the practice of complementary and alternative therapies, RNs are in a unique position to bridge the gap between conventional biomedical therapies and complementary and alternative therapies. Registered Nurses must act as advocates for their clients, and provide clients with information needed to make informed decisions about their health and health care; such information includes complementary and alternative therapies.

The Nursing Practice Act (NPA) defines the practice of nursing as those functions including "basic health care, that help people cope with difficulties in daily living that are associated with their actual or potential health or illness problems or the treatment thereof, and that require a substantial amount of scientific knowledge or technical skill including all of the following: direct and indirect patient care services..." (Section 2725). These direct and indirect patient services include the competence of RNs to provide information about complementary and alternative therapies, and to perform complementary and alternative procedures in accordance with the Standards of Competent Performance (CCR, Section 1443.5).

The ability of RNs to practice complementary and alternative therapies begins in nursing curricula/education. Nurses have the educational opportunities, in both theory and practice, to support the use of some complementary and alternative therapies with conventional therapies. For example, nursing students are taught how to manage pain. The nursing students then teach their clients about the complementary and alternative techniques for reducing pain such as focused breathing and relaxation, massage, guided imagery, music, humor, and distraction, as well as medication therapy used for reducing pain (conventional therapy.) The more complex complementary and alternative therapies become part of advanced **academic** education, frequently in the context of continuing education workshops or seminars; examples include acupressure, aromatherapy, massage, yoga, meditation, and reflexology. Acupuncture, **naturopathy**, and chiropractic require a license to practice in California. Applied kinesiology, herbal medicine, homeopathy, and ayurveda, usually require formal educational preparation and practice, and in some instances these therapies have private certification.

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COMPLEMENTARY AND ALTERNATIVE THERAPIES IN REGISTERED NURSING PRACTICE

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NURSING STUDENT WORKERS

A student nurse worker may not perform nursing functions beyond the level of a nursing assistant unless enrolled in a BRN approved Work Study Course in a California approved prelicensure nursing program.

Background:

The Nursing Practice Act permits students enrolled in a Board approved prelicensure nursing program to render registered nursing services when these services are incidental to a course of study in the program (Business and Professions Code 2729 (a)). A work-study course is offered by a nursing program complies with this section of law and provides additional clinical experiences for student nurses admitted to and enrolled in its own nursing program. With a work-study program, nursing students are exposed to the realities of the clinical environment and have the opportunity to master learned skills. Additionally, clinical agencies benefit by the student nurse's skills and have the opportunity to attract new graduate nurses to their facility.

Work-Study Program

The nursing programs in California are responsible for following the Board's guidelines in developing a work-study course as follows:

1) Nursing program develops a course in which previously learned nursing theory and clinical skills are applied

- A student must have acquired clinical competence in these skills. A list of skills competencies are provided to the clinical agency (work-study site).
- No new skills may be taught during this course
- Hours of instruction for the course follow the formula per CCR 1426(g)(2)
- A course faculty of record is available and is responsible for ongoing communication with students and agency and monitoring the student.

20 Nursing program develops an agreement with a clinical agency with which it has a contract, to provide a work-study course for which a student receives academic credit. Compensation of the student by the practice site is encouraged.

3) The clinical agency agrees to the objectives of the course and provides mentors or preceptors for direct supervision of students.

4) The instructor and agency mentors meet at regular intervals to discuss student progress and jointly share in the evaluation of the student.

5) The course instructor has the final responsibility to evaluate and grade students and their mastery of the course objectives.

Approval of work-study program

- All work-study courses require Board approval prior to course implementation.
- Nursing program submits a minor curriculum revision request to the assigned nursing education consultant following the curriculum revision guidelines.

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GUIDELINES FOR WORK STUDY COURSES

Background:
The Nursing Practice Act permits students enrolled in a Board approved prelicensure nursing program to render registered nursing services when these services are incidental to a course of study in the program (Business & Professions Code Section 2729[a]). A work-study course offered by a nursing program complies with this section of the law and provides additional clinical experiences for student nurses admitted to and enrolled in its own nursing program. With a work-study program, nursing students are exposed to the realities of the clinical environment and have the opportunity to master learned skills. Additionally, clinical agencies benefit by the student nurse's skills and have the opportunity to attract new graduate nurses to their facility.

Guidelines to develop a work-study course are as follows:

1) Nursing program develops a course in which previously learned nursing theory and clinical skills are applied.
   - A student must have acquired clinical competence in these skills. A list of skills competencies is provided to the clinical agency (work-study site).
   - No new skills may be taught during this course.
   - Hours of instruction for the course follow the formula per CCR 1426(g)(2).
   - A course faculty of record is available and is responsible for ongoing communication with students and agency and monitoring of student progress.

2) Nursing program develops an agreement with a clinical agency with which it has a contract, to provide a work-study course for which a student receives academic credit. Compensation of the student by the practice site is encouraged.

3) The clinical agency agrees to the objectives of the course and provides mentors or preceptors for direct supervision of students.

4) The instructor and agency mentors meet at regular intervals to discuss student progress and jointly share in the evaluation of the student.

5) The course instructor has the final responsibility to evaluate and grade students and their mastery of the course objectives.

Approval of work-study course:
- All work-study courses require Board approval prior to course implementation.
- Nursing program submits a minor curriculum revision request to the assigned nursing education consultant following the Curriculum Revision Guidelines (EDP-R-09).

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STUDENT WORKERS

A student nurse worker may not perform nursing functions beyond the level of a nursing assistant unless enrolled in a BRN approved student-worker course developed through collaboration of a Board approved nursing program and the health care facility employing the student.

In order to determine which functions such student workers and other nursing assistants may perform, first consider the following definition from the Nursing Practice Act:

> The practice of nursing means those functions, including basic health care, which
>
> (1) help people cope with difficulties in daily living,
>
> (2) are associated with their actual or potential health or illness problems or the treatment thereof,
>
> (3) require a substantial amount of scientific knowledge or technical skill.

As a general operating principle, basic health care functions which possess the first two characteristics may be performed by nursing assistants; functions which possess the third characteristic may not be performed by nursing assistants.

A few examples of functions possessing the third characteristic, i.e., require a substantial amount of scientific knowledge or technical skill, are nasogastric and gastrostomy feedings, tracheostomy care, catheterization, regulation of intravenous infusions and administration of drugs.

Although the mechanics of performing such procedures may be taught quite easily, the ability to assess the patient before and throughout the procedure and to respond appropriately to the patient's reactions derives from additional substantial scientific knowledge and technical skill, and for these reasons are excluded from the practice of unlicensed nurses.

The Attorney General, recently asked if certified nursing assistants can lawfully perform nasogastric or gastrostomy feeding, concluded that they may not. This conclusion was based on a review of the steps for performing the procedures and consideration of the potential for complications, such as the introduction of fluid into the patient's lungs with consequent patient harm. Nursing management may use this same process to make a determination regarding the suitability of assigning a function to a non-nurse.

Nursing management should be aware that the BRN

- holds nursing management responsible for making nursing assignments in accord with the Nursing Practice Act;
- investigates all reports/complaints of unlicensed nursing activity; and
- when evidence supports charges that a registered nurse has assigned a nursing assistant to perform registered nursing functions, takes appropriate disciplinary action against the responsible registered nurse.

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RN TELE-NURSING AND TELEPHONE TRIAGE

Website: **Telephone Medical Advice Services Bureau**
http://www.dca.ca.gov/tmas/

Introduction:
The public is being directed by health care insurers, providers, and private businesses to have their health care questions answered by registered nurses. Individuals contact the Board with questions regarding who can carry out telephone interactions with patients about health symptoms, conditions, or concerns.

Callers often indicate that they participate in activities termed tele-nursing or triage, however the descriptions vary. Callers describe activities that involve interviewing and assessing the condition of the patient and determining the appropriate intervention. The intervention may be counseling the patient to administer self-care at home, advising the patient to go immediately to an urgent care or emergency room setting, or utilizing a protocol (standardized procedure) to advise the client of a specific treatment or to generate a predetermined prescription for the patient.

The Board of Registered Nursing receives many inquires from nurses, associations and the public about the RN's legal authority to provide telephone nursing advice and/or nursing telephone triage services. The Business and Professions Code, Nursing Practice Act, Section 2725 provides the authority for registered nursing practice. The BRN interprets RN scope of practice to include tele-nursing and telephone triage.

A California RN license is required for in-state or out-of state RNs to perform telephone medical advice services to California addresses. It is incumbent upon the RN to be knowledgeable and competent in the practice when offering telephonic assessment, evaluation, referral, or advice to patients or their family members.

Background:
Effective January 2000, a new law titled "Telephone Medical Advice Services" was added to the California Business and Profession Code, Chapter 15, Section 4999-4999.9. Chapter 15 of the Business and Professions Code requires businesses that employ at least 5 full time equivalent employees in-state or out-of-state that provide telephone medical advice to California addresses to register with the Telephone Medical Advice Services Bureau, Department of Consumer Affairs. All personnel who provide telephone medical advice at these businesses must be appropriately registered or licensed healthcare professionals in California. To protect the California healthcare consumers, the law and regulations require providers of telephone medical advice to maintain records of telephone medical advice services including complaints for at least 5 years. The telephone medical advice business is charged with ensuring the telephone medical advice they provide is consistent with good professional judgment.

Definition:
"Telephone medical advice" means a telephonic communication between a patient and a health care professional, wherein the health care professional's primary function is to provide the patient a telephonic response to the patient's questions regarding his or her or a family member's medical care or treatment.

Board of Registered Nursing: general information (916) 322-3350 and website: www.rn.ca.gov

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RN TELE-NURSING AND TELEPHONE TRIAGE

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Board of Registered Nursing:
If you have any questions about California RN scope of practice, you can contact the BRN at (916) 322-3350 or visit the Web site at www.rn.ca.gov. For information about business requirements for Telephone Medical Advice Services (TMAS), you can contact (916) 574-7992 or visit the Web site www.dca.ca.gov/tmas.

If you have question about the California LVN's scope of practice, please contact the Board of Vocational Nursing and Psychiatric Technicians at (916) 263-7800.

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REPRODUCTIVE PRIVACY ACT

Website: http://leginfo.ca.gov/

Effective January 1, 2003

Senate Bill 1301 (Kuehl), Chapter 385, was signed by Governor Gray Davis on September 5, 2002. The Reproductive Privacy Act provides that every individual possesses a fundamental right to privacy with respect to reproductive decisions, including (A) the fundamental right to choose or refuse birth control, and (B) the fundamental right to choose to bear children or obtain an abortion. This new law provides that the state shall not deny or interfere with woman's fundamental right to choose to bear a child or obtain an abortion prior to viability of the fetus, as defined, or when necessary to protect her life and health.

The Reproductive Privacy Act deletes the provisions of the Therapeutic Abortion Act including the name of the act.

The Reproductive Privacy Act enacts changes to the Business and Professions Code, Section 2253 to allow registered nurses, certified nurse practitioners, certified nurse-midwives with valid, unrevoked, and unsuspended licenses or certificates to assist in the performance of a surgical abortion and to assist in the performance of non-surgical abortion.

The BRN's interpretation is that the registered nurse, certified nurse practitioner, or certified nurse-midwife may perform the nursing functions necessary to assist with a surgical abortion.

The BRN's interpretation is that the registered nurse may perform or assist in performing the functions necessary for a nonsurgical abortion including medication administration and patient teaching.

The nurse practitioner or nurse-midwife may perform or assist in performing functions necessary for nonsurgical abortion by furnishing or ordering medications in accord with his or her approved standardized procedures.

The Reproductive Privacy Act includes the following definitions:

"Abortion" means any medical treatment intended to induce the termination of a pregnancy except for the producing of a live birth.

"Pregnancy" means the human reproductive process, beginning with the implantation of an embryo.

"State" means the State of California, and every county, city, town and municipal corporation, and quasi-municipal corporation in the state.

"Viability" means the point in a pregnancy when, in the good faith medical judgment of a physician, on the particular facts of the case before that physician, there is a reasonable likelihood of the fetus's sustained survival outside the uterus without the application of extraordinary medical measures.

The performance of an abortion is unauthorized if either of the following is true:

- The person performing or assisting in performing the abortion is not a health care provider authorized to perform or assist in performing an abortion pursuant to Section 2253 of the Business and Professions Code.
- The abortion is performed on a viable fetus, and both of the following are established.
  - In the good faith medical judgment of the physician, the fetus was viable.
  - In the good faith medical judgment of the physician, continuation of the pregnancy posed no risk to life or health of the pregnant woman.

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STANDARDIZED PROCEDURE GUIDELINES

Website: http://www.rn.ca.gov/regulations/title16.shtml#1470

ARTICLE 7. STANDARDIZED PROCEDURE GUIDELINES

1470. Purpose

The Board of Registered Nursing in conjunction with the Division of Allied Health Professions of the board of Medical Quality Assurance (see the regulations of the Board of Medical Quality Assurance, Article 9.5, Chapter 13, Title 16 of the California Code of Regulations) intends, by adopting the regulations contained in the article, to jointly promulgate guidelines for the development of standardized procedures to be used in organized health care systems which are subject to this rule. The purpose of these guidelines is:

(a) To protect consumers by providing evidence that the nurse meets all requirements to practice safely.

(b) To provide uniformity in development of standardized procedures.

1471. Definitions

For purposes of this article:

(a) "Standardized procedure functions" means those functions specified in Business and Professions Code Section 2725(c) and (d) which are to be performed according to "standardized procedures";

(b) "Organized health care system" means a health facility which is not licensed pursuant to Chapter 2 (commencing with Section 1250), Division 2 of the Health and Safety Code and includes, but is not limited to, clinics, home health agencies, physicians' offices and public or community health services;

(c) "Standardized procedures" means policies and protocols formulated by organized health care systems for the performance of standardized procedure functions.

1472. Standardized Procedure Functions

An organized health care system must develop standardized procedures before permitting registered nurses to perform standardized procedure functions. A registered nurse may perform standardized procedure functions only under the conditions specified in a health care system's standardized procedures; and must provide the system with satisfactory evidence that the nurse meets its experience, training, and/or education requirements to perform such functions.

1473. Standardized Procedures

NOTE: Authority cited: Section 2715, Business and Professions Code. Reference: Section 2725, Business and Professions Code. HISTORY: Repealed 12-4-85.

1474. Standardized Procedure Guidelines

Following are the standardized procedure guidelines jointly promulgated by the Division of Allied Health Professions of the Board of Medical Quality Assurance and by the Board of Registered Nursing:

(a) Standardized procedures shall include a written description of the method used in developing and approving them and any revision thereof.

(b) Each standardized procedure shall:

(1) Be in writing, dated and signed by the organized health care system personnel authorized to approve it.

(2) Specify which standardized procedure functions registered nurses may perform and under what circumstances.

(3) State any specific requirements which are to be followed by registered nurses in performing particular standardized procedure functions.

(4) Specify any experience, training, and/or education requirements for performance of standardized procedure functions.

(5) Establish a method for initial and continuing evaluation of the competence of those registered nurses authorized to perform standardized procedure functions.

(6) Provide for a method of maintaining a written record of those persons authorized to perform standardized procedure functions.

(7) Specify the scope of supervision required for performance of standardized procedure functions, for example, immediate supervision by a physician.

(8) Set forth any specialized circumstances under which the registered nurse is to immediately communicate with a patient's physician concerning the patient's condition.

(9) State the limitations on settings, if any, in which standardized procedure functions may be performed.

(10) Specify patient record keeping requirements.

(11) Provide for a method of periodic review of the standardized procedures.

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STANDARDS OF COMPETENT PERFORMANCE

Website: http://www.rn.ca.gov/regulations/title16.shtml#1443.5

1443.5. STANDARDS OF COMPETENT PERFORMANCE

A registered nurse shall be considered to be competent when he/she consistently demonstrates the ability to transfer scientific knowledge from social, biological and physical sciences in applying the nursing process, as follows:

(1) Formulates a nursing diagnosis through observation of the client's physical condition and behavior, and through interpretation of information obtained from the client and others, including the health team.

(2) Formulates a care plan, in collaboration with the client, which ensures that direct and indirect nursing care services provide for the client's safety, comfort, hygiene, and protection, and for disease prevention and restorative measures.

(3) Performs skills essential to the kind of nursing action to be taken, explains the health treatment to the client and family and teaches the client and family how to care for the client's health needs.

(4) Delegates tasks to subordinates based on the legal scopes of practice of the subordinates and on the preparation and capability needed in the tasks to be delegated, and effectively supervises nursing care being given by subordinates.

(5) Evaluates the effectiveness of the care plan through observation of the client's physical condition and behavior, signs and symptoms of illness, and reactions to treatment and through communication with the client and the health team members, and modifies the plan as needed.

(6) Acts as the client's advocate, as circumstances require by initiating action to improve health care or to change decisions or activities which are against the interests or wishes of the client, and by giving the client the opportunity to make informed decisions about health care before it is provided.

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THE RN AS FIRST ASSISTANT TO THE SURGEON

Association of periOperative Registered Nurses, AORN Standards and Recommended Practices: www.aorn.org

AORN-RN First Assistant: http://www.aorn.org/CareerCenter/CareerDevelopment/RNFirstAssistant/

AORN Standards for RN First Assistant Education Program are available AORN Perioperative Standards and Recommended Practices. See above website

The role of RN first assistant to the surgeon requires the performance of a combination of nursing and medical functions. The RN first assistant directly assists the surgeon by controlling bleeding, providing wound exposure, suturing and other surgical tasks. The RN first assistant may provide other advanced assistance, such as mobilization of tissue, patient positioning and directing other surgical team members with specific individual tasks. The RN first assistant, practices perioperative nursing and must have acquired the necessary specific knowledge, skills and judgment. The RN first assistant practices under the supervision of the surgeon during the intraoperative phase of the perioperative experience. In order to perform those functions considered to be first assistant to the surgeon, the RN must adhere to standardized procedures.

STANDARDIZED PROCEDURES FOR MEDICAL FUNCTIONS

The means designated to authorize performance of a medical function by a registered nurse is a standardized procedure developed through collaboration among registered nurses, physicians and administrators in the **organized health care system** in which it is to be used. Because of this interdisciplinary collaboration, there is accountability on several levels for the activities to be performed by the registered nurse. Business and Professions Code, §2725 © defines "organized health care systems" as facilities licensed by Health and Safety Code (section 1250) meaning licensed health facilities and the California Code of Regulations, defines "organized health care system" not licensed in by Health and Safety (section) as described in CCR § 1471 to include, but are not limited to, clinics, home health agencies, physician' offices, and public or community health services.

GUIDELINES FOR DEVELOPING STANDARDIZED PROCEDURES

Standardized procedures are not subject to prior approval by the boards that regulate nursing and medicine; however, they must be developed according to the following guidelines which were jointly promulgated by the Board of Registered Nursing and the Medical Board of California. (Board of Registered Nursing, Title 16, California Code of Regulations (CCR) Section 1474; Medical Board of California, Title 16 CCR Section 1379.)

(a) Standardized procedures shall include a written description of the method used in developing and approving them and any revision there of.

(b) Each standardized procedure shall:

1) **Be in writing, dated and signed by the organized health care system** personnel authorized to approve it.
2) Specify **which standardized procedure functions** registered nurses may perform and under what circumstances.
3) State any specific **requirements which are to be followed** by registered nurses in performing particular standardized procedure functions.

4) Specify any **experience, training and/or education** requirements for performance of standardized procedure functions.
5) Establish a method for initial and continuing **evaluation** of the competence of those registered nurses authorized to perform standardized procedure functions.
6) Provide for a method of maintaining a written record of those **persons authorized to perform** standardized procedure functions.
7) Specify the scope of supervision required for performance of standardized procedure functions, for example, telephone contact with the physician.
8) Set forth any specialized circumstances under which the registered nurse is to immediately **communicate with a patient's physician** concerning the patient's condition.
9) State the limitations on **settings**, if any, in which standardized procedure functions may be performed.
10) Specify patient **record-keeping** requirements.
11) Provide for a method of **periodic review** of the standardized procedures.

An additional safeguard for the consumer is provided by steps four and five of the guidelines which, together, form a **requirement that the nurse be currently capable** to perform the procedure. The registered nurse who undertakes a procedure without the competence to do so is grossly negligent and subject to discipline by the Board of Registered Nursing.

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The RN first assistant is not the same as an individual designated to perform scrub functions. A "scrub technician" is any individual not licensed to practice professional nursing who passes the surgeon the surgical instruments, sponges, and other items needed during the surgical procedure. The Board has interpreted that a non-licensed individual may perform scrub functions only as an assigned technical function under the direct supervision of a perioperative registered nurse.

Criteria for education of the registered nurse in the role of surgical first assistant would include theory and clinical to provide demonstrated competency in:

- Performing individualized surgical care management before, during and after surgery.
- Surgical anatomy and physiology and surgical technique related to first assisting.
- Carrying out intraoperative behaviors including handling tissue, providing exposure, using surgical instruments, suturing and controlling blood loss.
- Application of principles of asepsis and infection control.
- Recognizing surgical hazards and initiation of appropriate corrective and preventative actions.

It is recommended that RNs qualifying as first assistants have documented proficiency in perioperative nursing practice in both a scrub and circulation roles. It is important to be aware that although the RN may perform the first assistant's surgical duties, the RN does not possess the same medical surgical knowledge, skill, and judgment that a surgeon does and provisions should be made to protect the consumers' health in the event the surgeon could not continue for any reason.

ESTABLISHMENT OF CLINICAL PRIVILEGES FOR THE RN FIRST ASSISTANT

The process of granting clinical privileges should include the following mechanisms:

- assessing individuals qualifications for practice
- assessing initial and yearly proficiency performance
- assessing compliance with institutional and departmental polices
- defining lines of accountability
- quality improvement methods including peer review

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STANDARDIZED PROCEDURE EXAMPLES

The attached examples are not required formats. The Board of Registered Nursing does not recommend or endorse the medical/surgical management of these example protocols.

RNFA STANDARDIZED PROCEDURE

I. Standard

The RN First Assistant renders direct patient care as part of the perioperative role by assisting the surgeon in the surgical treatment of the patient. The responsibility of functioning as first assistant must be based on documented knowledge and skills acquired after specialized preparation and formal instruction.

II. Policy

A. The safety and welfare of the patient should be given primary consideration in the selection of a first assistant in surgery. In the absence of a qualified physician, the registered nurse who possesses appropriate knowledge and technical skills is the best qualified non-physician to serve as the first assistant.

B. The RNFA practices under the direct supervision of the surgeon during the surgical intervention.

C. The RNFA must perform only as first assistant and not concurrently as scrub nurse.

D. Only in extreme emergencies should an RNFA be expected to assist on procedures that present an unusual hazard to life.

E. The RNFA must adhere to the policies of the institution and must remain within the scope of practice as stated by the Nursing Practice Act of the State of California.

F. The RNFA may perform technical functions:

1. Assist with the positioning, prepping and draping of the patient or perform these independently, if so directed by the surgeon.

2. Provide retraction by:
   a. Closely observing the operative field at all times.
   b. Demonstrating stamina for sustained retraction.
   c. Retaining manually controlled retractors in the position set by the surgeon with regard to surrounding tissue.
   d. Managing all instruments in the operative field to prevent obstruction of the surgeon's view.
   e. Anticipating retraction needs with knowledge of the surgeon's preferences and anatomical structures.

3. Provide hemostasis by:
   a. Applying electrocautery tip to clamps or vessels in a safe and knowledgeable manner as directed by the surgeon.
   b. Sponging and utilizing pressure as necessary.
   c. Utilizing suctioning techniques.
   d. Applying clamps on superficial vessels and the tying off, electrocoagulation of them as directed by the surgeon.
   e. Placing suture ligatures in the muscle, subcutaneous, and skin layers.
   f. Placing hemoclips on bleeders as directed by the surgeon.

4. Perform knot tying by:
   a. Having knowledge of the basic techniques.
   b. Tying knots firmly to avoid slipping.
   c. Avoiding undue friction to prevent fraying of suture.
   d. Carrying knot down to the tissue with the tip of the index finger and laying the strands flat.
   e. Approximating tissue rather than pulling tightly to prevent tissue necrosis.

5. Provide closure of layers by:
   a. Correctly approximating the layers under the direction of the surgeon.
   b. Demonstrating a knowledge of different types of closure.
   c. Correctly approximating skin edges when utilizing skin staples.

6. Assist the surgeon at the completion of the procedure by:
   a. Affixing and stabilizing all drains.
   b. Cleaning the wound and applying the dressing.
   c. Assist with applying casts or plaster splints.

NOTE: The above specifications are general guidelines and do not reflect all duties in all specialty areas. Therefore, they should not preclude the performance of other duties which, in the judgment of the surgeon, can be successfully accomplished by the RN First Assistant. However, the RN First Assistant must know his/her limitations and may refuse to perform those functions for which he/she has not been prepared or which he/she does not feel capable of performing.

STANDARDIZED PROCEDURE

Procedure: Intraoperative Retracting

Personnel: Registered Nurse First Assistants

Purpose: To direct the RNFA in providing retraction of the surgical field

Desired Outcome: Adequate surgical exposure without subsequent tissue/organ compromise.

Supportive Data: Selection and placement of an appropriate retraction instrument will assist the surgeon by providing exposure and optimum visualization of the surgical site.

Process: The RNFA will assist the surgeon by providing intraoperative retraction using the following measures:

1. Retracting tissues or organs by the use of the hand.
2. Placing and holding surgical retractors.
3. Packing sponges or laporotomy pads into body cavities to hold tissues and organs out of the operative field.
4. Managing all instruments in the operative field to prevent obstruction of the surgeon's view.

STANDARDIZED PROCEDURE

Procedure: Intraoperative Wound Closure

Personnel: Registered Nurse First Assistants

Purpose: To direct the RNFA in providing proper suturing of tissue during a surgical procedure.

Desired Outcome: Tissue will heal as expected without complications from the suturing process.

Supportive Data: Proper suturing is vital to insure hemostasis, wound alignment, and tissue healing.

Process: The RNFA will suture tissue, using instruments and suture material as directed by the surgeon, by:

1. Correctly approximating tissue layers.
2. Approximating tissue appropriately to avoid excess tension and tissue necrosis.
3. Tying knots firmly to avoid slipping.
4. Using staples, clips, or other devices to approximate tissue.

STANDARDIZED PROCEDURE

Procedure: Intraoperative Hemostasis

Personnel: Registered Nurse First Assistants

Purpose: To direct the RNFA in providing Hemostasis of the surgical field.

Desired Outcome: Minimal blood loss during surgery.

Supportive Data: Providing a dry operative field promotes adequate visual assessment and access to the surgical site. Effective hemostasis is essential to carry out surgery in a time-efficient manner and to prevent excessive blood loss.

Process: The RNFA will assist the surgeon by providing intraoperative hemostasis using the following measures:

1. Aspiration of blood and other fluids from the operative site, as directed by the surgeon.
2. Sponging the wound or other area of dissection, as directed by the surgeon.
3. Using hemostasis or other surgical instruments to clamp bleeding tissue, as directed by the surgeon.
4. Using sutures to tie off clamped blood vessels or other tissue, as directed by the surgeon.
5. Using electrocautery or other surgical device to cauterize tissue, or surgical instruments clamped to tissue.
6. Place hemoclip, or other ligating devices on vessels or tissue, as directed by the surgeon.

STANDARDIZED PROCEDURE

Procedure: Intraoperative Tissue Manipulation

Personnel: Registered Nurse First Assistants

Purpose: To direct the RNFA in the manipulation of tissue and use of surgical instruments during a surgical procedure.

Desired Outcome: No tissue damage due to improper handling, or use of surgical instruments.

Supportive Data: Proper handling of tissue and selection and use of surgical instruments is essential to proper treatment of tissue and rapid healing of the surgical site.

Process: The RNFA will use surgical instruments and suture material to manipulate tissue, as directed by the surgeon, to:

1. Expose and retract tissue.
2. Clamp and sever tissue.
3. Grasp and fixate tissue with screws, staples, and other devices.
4. Drill, ream, and modify tissue.
5. Cauterize and approximate tissue.

PROCEDURE FOR THE RNFA IN THE EVENT THE SURGEON BECOMES INCAPACITATED OR NEEDS TO LEAVE FOR AN EMERGENCY DURING SURGERY

1. In the event the operating surgeon, during surgery, becomes incapacitated or needs to leave the OR due to an emergency, the responsibility of the RNFA is to:
   a. Maintain hemostasis, according to the approved standardized procedure.
   b. Keep the surgical site moistened, as necessary, according to the type of surgery.
   c. Maintain the integrity of the sterile field.
   d. Remain scrubbed in appropriate attire (gown, mask, gloves, cap).
   e. Remain at the field while a replacement surgeon is being located.

2. The RN circulator will initiate the procedure for obtaining a surgeon in an emergency.

MEDICAL CENTER: **NURSING Operating Room**	POLICY/PROCEDURE TITLE: Standard Procedure for Registered Nurse First Assistant
DISTRIBUTE TO:	[ ] ADMINISTRATIVE [ ] CLINICAL PAGE 1 OF 2
RELATED TO: [ ] Hospital Instruction (HU) [x] Nursing Practice Stds. [ ] JCAHO NC.1 - 1.2.1 [ ] Patient Care Stds. [ ] QA [ ] Other [x] Title 22	Effective Date: Revision Date: Unit/Department of Origin: Approved by: Interdisciplinary Practice Committee File Name: ORNURSE.p&p

I. PURPOSE:

This standardized procedure will provide guidelines for the registered nurse assisting the surgeon in the first assistant role.

II. POLICY STATEMENT:

The RNFA may function in the expanded role, provided in this standardized procedure, which is approved by the Interdisciplinary Practice Committee. This role requires the direct supervision of the sponsoring primary surgeon.

III. GENERAL GUIDELINES:

A. The RNFA will assist the surgeon by providing intraoperative retraction giving exposure and optimum visualization of the surgical site as directed by the surgeon.

1. Retracting tissue or organs by the use of the hand, closely observing the operative field at all times.
2. Placing or holding surgical retractors in the position set by the surgeon with regard to surrounding tissue.
3. Packing sponges into body cavities to hold tissue or organs out of the operative field.
4. Managing all instruments in the operative field to prevent obstruction of the surgeons views.

B. The RNFA will assist the surgeon by providing intraoperative hemostasis promoting adequate visual assessment and access to the surgical site as directed by the surgeon.

1. Aspiration of blood and other fluids from the operative site using suctioning techniques.
2. Sponging the wound and utilizing pressure as directed.
3. Placing hemostats on other instruments to clamp tissue or bleeding vessels.
4. Applying electrocautery tip to clamps or vessels as directed.
5. Placing suture ligatures on vessels or tissue as directed.
6. Perform knot tying firmly to avoid slipping.

C. The RNFA will use surgical instruments to perform dissection or manipulate tissue as directed by the surgeon.
   1. Dissects only those layers required to provide exposure to the operative area as directed.
   2. Dissect only the superficial tissue of lower extremity veins during cardiac or vascular surgery as directed.
   3. Grasps and fixates tissue with staples or screws.
   4. Drills and modifies bone tissue as directed.

D. The RNFA will suture tissue and insure hemostasis or wound alignment as directed by surgeon.
   1. Approximating tissue layers as directed to avoid excess tension or tissue necrosis.
   2. Uses suture, staples, skin clips or other devices to correctly approximate tissue.

IV. REQUIREMENTS FOR RN PRIVILEGED IN THEIR EXPANDED ROLE:

A. Will meet all requirements of the hospital Non-physician/Non-Employee Policy.
B. Certified in basic Cardiopulmonary life support.
C. Nationally certified operating room nurse through the Association of Operating Room Nurses (AORN).
D. Minimum of three (3) years of operating room experience in both the scrub and circulating roles.
E. E.Proof of successful completion of a structured RNFA course and completion of 20 hours or 10 cases of proctoring by the sponsoring surgeon.
F. Will receive approval from the surgical sub-specialty of the sponsoring physician.
G. Will be evaluated by the hospital staff for compliance to OR policies and by the sponsoring surgeon annually.

V. DEVELOPMENT AND APPROVAL OF STANDARDIZED PROCEDURE:

A. This policy will be developed and approved by authorized representatives of administration, medicine, and nursing.
B. This standardized procedure will be reviewed and approved every three years.

1. Administration _____Date _____
2. Medicine _____ Date _____
3. Nursing _____ Date _____

VI. RN'S AUTHORIZED TO PERFORM STANDARDIZED PROCEDURE:

1. _____ Date _____
2. _____ Date _____
3. _____ Date _____